NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

July 25, 2012

1. Please join my meeting.
https://www3.gotomeeting.com/join/739608606

2. Use your microphone and speakers (VoIP) - a headset is recommended. Or, call in using your telephone.

Dial +1 (805) 309-0012
Access Code: 739-608-606
Audio PIN: Shown after joining the meeting

Meeting ID: 739-608-606

QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSRSN region. In assessing the necessary data and making appropriate recommendations, the QMOC members agree to the following:

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10/27/99
Revised: 1/17/01

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: July 25, 2012 **Time: 1:00-3:00 PM**
Location: NSMHA Conference Room
For information Contact Meeting Facilitator: Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates	• Special Populations Consultant • Fund balance RFP and Outpatient Services RFQ	Inform /discuss	Greg Kurt			**3**	*10 min*
Evaluation forms from last meeting, if any	Discuss feedback, if any.	Inform /discuss	Chair/ Greg				*5 min*
		Quality Topics					
Focused Clinical Improvement Meeting Process (Clinical Forums)	Follow-up on Ombuds recommendation that there be discussions on key clinical issues	Inform/ discuss	Greg	Committee Discussion Form		**4**	*15 min*
Children's Mental Health Class Action and use of CANS Tool for children	Children's mental health is progressing in response to a class action suit. A major focus is to be Family/Child Teams	Introduce/ inform	Charissa	Committee Discussion Form		**5**	*10 Min*
Healthy Options Services	Presentation of State-wide RSN/Healthy Options Agreement.	Inform/ discuss	Greg	Committee Discussion Form		**6**	*10 min*
Changes in critical incidents policy.	Review new policies and procedures and form		Kurt	Committee Discussion Form		**7**	*10 min*
General Contract Changes	Changes to DBHR Contracts		Greg	Committee Discussion Form		**8**	*10 min*
Implementation of Customer Satisfaction Survey	Introduction to the 2012 Regional Customer Satisfaction Survey. Present implementation and timeline	Inform/ discuss	Kurt	Committee Discussion Form		**9**	*15 min*
UR Results	Report of 2012 Routine UR Reviews	Inform/ discuss	Charissa	Committee Discussion Form		**10**	*10 min*
Other issues							
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: August 22, 2012 - 1:00-3:00 PM **Potential Future Agenda Items:**

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
May 30, 2012
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: **David Kincheloe** & **Mark McDonald**, NSMHA Advisory Board, **Marie Jubie**, Sno. Co. Agency on Aging; **Larry Van Dyke**, Pioneer Services; **Stacey Alles**, Compass Health; **Dan Bilson**, Advisory Board Representative-Whatcom Co.; **Kate Scott,** Sea Mar; **Kathy McNaughton**, CCS; **Mike Manley**, Sunrise Services; **Kay Burbidge,** LWC & **Anne Deacon**, Whatcom Co.
BY PHONE: Pat Morris, VOA; **Cindy Ferraro**, Bridgeways; **Pam Benjamin**, WCPC; **Susan Ramaglia**, NSMHA Advisory Board & **Nancy Jones**, Snohomish County.
STAFF: Greg Long, Charissa Westergard and **Barbara Jacobson**.
OTHERS PRESENT: **Heather Fennell**, Compass Health; **Cammy Prince** and **Carol Van Buren**, Sunrise Services.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	The meeting is called to order at 1:08 pm and introductions are made. Greg noted that the missing discussion form was sent out via email today. Additions to the agenda were called for and none were mentioned.	
2. Previous Meeting Summary – Chair	The meeting summary is reviewed and is approved as presented. Stacey noted the short notice on the meeting reschedule and the short timeline to review the packet prior to the meeting; rescheduling on short notice is inconvenient.	Approved
3. Announcements and Updates – All	• Anne announced that QMOC and the Planning Committee will have new chair assignments. Regina Delahunt will step down from the Planning Committee and Anne will assume that role; Rebecca C will then step in to Chair QMOC. • Online Crisis Plans – Greg noted that providers have until August 1, 2012 to be ready to implement the new download. These plans will then be available almost immediately on the portal that VOA will use to access them. • Greg thanked all providers as NSMHA has received the information for the Less Restrictive (LR) contacts at Providers.	Informational
4. Evaluation Forms from Last Meeting – Chair/Greg	Anne reviewed the feedback received on the forms from the last meeting and reminded all to fill out the evaluation forms at the back of the binder.	Informational
5. Focused Clinical Improvement Meeting Process	Greg noted that this topic is from a recommendation from the Ombuds in their last report; where they recommended forming a regional clinical forum to discuss common core issues of those difficult to treat. Specific cases would not be discussed but would address overall issues in a more formal process. Greg noted he thought perhaps to schedule it before or after QMOC for convenience for a quarterly meeting. In the Ombuds report it was noted that it is difficult to resolve some complaints with the clients that are	Add to next agenda. Request data from Ombuds.

	highly symptomatic. This discussion will be brought forward to the next agenda when Ombuds can be present for a full discussion before we move forward. We will request that Ombuds provide some data beforehand on the recurring clinical issues and what gets them stuck in the process of resolution.	
6. Routine UR Revision Requests	Charissa noted the Utilization Reviews (UR) were done February through April; this is a review of charts to see if clients are getting the correct level of services. The reviewer writes a letter to the agency with any areas to address and the agency has 30 days to respond. This can go up to 60 days on a case by case basis. The chart attached shows those over the timeline. This is a reminder for agencies to get this squared away. Heather noted that Compass has received repeat requests for those already submitted and this could be part of the problem; Charissa acknowledged that this does occur and to let her know of these. Stacey noted that it would save time on both ends to have this repeat issue resolved.	Informational
7. North Sound System Providing Healthy Options Services	The State issued an RFP to find health plans to serve clients in our state. Five health plans were selected to oversee the Healthy Options program which combines physical, mental and substance abuse treatment into one plan. The new plans need to start July 1, 2012 and one plan has approached us to manage the mental health portion. This is a small benefit of 20 visits per year for kids and 12 visits for adults. Greg noted this would be a new area for the RSN and he is seeking feedback from providers; do any currently contract with them already. Compass noted that they do currently. Mike M noted the large number that will be switched from Group Health and Regence and that this will create chaos for clients. Discussion points: • Takes the choice and negotiation out of provider's hands if the RSN negotiates/accepts the rates for all in contracting with these. • What extra work will be required of providers by these contracts as the rates will be lower. • This is about these managed care organizations showing the state they have a provider network by July 1 deadline and not to our benefit. • This could create more client choice. • What would NSMHA be expected to do as the contractor such as UR or eligibility and other oversight. How much regulation will come with these contracts. • Sea Mar needs more time to review before they provide feedback on how they might help fill the gap. • If the rates shown on the HCA website are accurate they are significantly lower. • Providers would use more of their cap on full assessments for those not meeting access to care. Pre-screening process could be developed.	Informational Add to agenda for Integrated Provider meeting.

	• Are some already being served by FQHCs (Federally Qualified Health Clinic) and could this be pursued further. • Capacity, not all providers have capacity and this may drain more Medicaid funding. There are many questions and concerns that remain before providers feel they can support. This will go to Integrated Provider Meeting and we hope to have some more details on rates and policies by then. Stacey noted that each of these organizations must have a cooperation agreement with RSNs to coordinate regardless.	
8. Proposed Contract Amendments	Greg noted that this is a near final draft of the contract language changes that will come on the first on July; the state will be pushing more outreach services and assessments to nursing homes, AFHs and homes to prevent hospitalization. He noted that the language about enrollee preference could be updated due to feedback so that preference is not the only reason. Dementia is a B category and those in our system will usually have another diagnosis such as depression. Greg noted we will get the language out to all as soon as we get it. The State has left the two decertified wards at WSH open for dementia but this is still a limited resource. DBHR has not said there will be any extra funding for the extra work and expense by providers to outreach.	Informational
9. Provision of Specialized Services	Greg noted that this to address treating those with specialized issues such as eating disorders and DID. Consultation was mentioned last time as an approach and Greg noted that Compass sends clients to a King Co clinic if they have hearing disorders. When these situations arise provider agencies need to arrange and manage care for consumers. NSMHA recommends sending consumers to an independent specialist for an expert assessment when they may require long-term out of network services.	Informational
10. Housing Complaints	NSMHA would like providers with housing programs or other non-RSN funded programs, such as payee services to identify their contacts for complaints.	Informational
11. Parent Initiated Treatment	Charissa noted that this new RCW offers parents more control to initiate care without the minors consent. This is to initiate voluntary inpatient treatment for kids ages 13-18. This has been discussed at both the ICRS and Inpatient meetings as well.	Informational
12. Open Forum	David noted that it would be helpful on items where there is a change in language to also include the old language for complete review. It would also be helpful if the discussion forms could more clearly outline the key issue or question that is to be addressed or action needed on that topic. This would more clearly outline what is needed from the committee.	Discussion
13. Date and Agenda for Next Meeting	The meeting was adjourned at 2:50 pm. The next meeting is June 27, 2012.	

2012 SPECIAL POPULATIONS MH SPECIALIST CONSULTANT ROSTER - June 2012

SPECIAL POPULATION	Willingness confirmed by independent consultant	Willingness confirmed by independent consultant	Willingness confirmed by independent consultant	Willingness confirmed by independent consultant	Unconfirmed alternative #1	Unconfirmed alternative #2
African American	Belle Nishioka (206) 299-0387 fax: (206) 783-5558	Jerry Green 19326 Locust Way Lynnwood, WA 98036 425.652.1886				
American Indian or Alaskan Native	Kathryn Fentress 360.738.6884	Ricki Jacobs (360) 876-2905 cell: (360) 509-7854	Bonita Holbrook, MSW Native American Consults bonneh@earthlink.net (360) 790-8379	Pala Hope Simeona hm (206) 782-7766 cell ((206) 371-5213 palahope@comcast.net		
Asian/Pacific Islander	Belle Nishioka (206) 299-0387 fax: (206) 783-5558	Beverly Chase 206.354.2889	Janine Dinio (360)692-4174	Asian Counseling & Referral Services (206) 695-7600	Asian Counseling Serv. (253) 301-5250	
Hispanic	Ricardo Hildago 206.659.8053	Janine Dinio (360) 692-4174	Griselda Perretz-Rosales, Ph.D. (360) 943-2555		Northwest Family Therapy Institute (360) 352-0064	
Developmental Disabilities	Andy Byrne argbyrne@comcast.net	Rick Tabor (all ages) *Sound Mental Health* (206) 302-2372 rickt@smh.org				
Older Person ≥ 60	Betty Rogers 360.445.2302	Salim Kassis *Sound Mental Health* (206) 302-2630				
Blind	Kim Curry kim@curryz.com (360) 771-8665					
Deaf	Dr. Susan Kane-Ronning 360.714.8109	Ann Baldwin *Sound Mental Health* (206) 302-2811			Jeanne Hehlen JeanneH@crmhs.org (503) 680-6652	Beng Ligasan *Sound Mental Health* (206) 302-2372
Child & Youth	NA - All Child/youth programs have specialists on site.					

NOTE: The above table is a resource to consider when providers are seeking to subcontract with consultant services in one or more special populations category. NSMHA has not credentialed any of the consultants on the list, and therefore this list does not serve as an endorsement of the use of the individuals. Credentialing remains the responsibility of the provider agencies during the subcontracting process.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Clinical Forums

PRESENTER: Greg Long/Ombuds

COMMITTEE ACTION: **Action Item (x) FYI & Discussion (x) FYI only ()**

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
This is a follow-up of this proposal from Ombuds which has been discussed at several meetings. Ombuds in their last report recommended setting up forums on reoccurring clinical issues. Ombuds stated:

We recommend NSMHA consider forming a regional team to discuss common, core issues of difficult-to-treat clients—problems of delusion, inappropriate behavior, paranoia, meds refusal and chemical dependency for example. The team would discuss these issues and eventually develop practices that prove most effective locally. We recommend NSMHA introduce this to the Quality Management Oversight Committee and tie in the concepts of using motivational interviewing and peer counselors.

CONCLUSIONS/RECOMMENDATIONS:
NSMHA proposes that we try a 90 minute clinical forum on a quarterly basis for one year on a specific topic. NSMHA will arrange for our Medical Director to lead two of these forums and requests that providers have one of their clinical staff lead two of these forums. QMOC would select the topics. These forums might lead to clinical programming changes or guidelines which could be handled through our ongoing quality management and QMOC processes.

TIMELINES:

ATTACHMENTS: None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Children's Mental Health Class Action (*T.R. et al v. Dreyfus*)

PRESENTER: Charissa Westergard/Greg Long

COMMITTEE ACTION: Action Item () FYI & Discussion () FYI only (X)

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
From DSHS news release (http://www.dshs.wa.gov/mediareleases/2012/pr12015.shtml), "*T.R. et al v. Dreyfus* was filed in November 2009 alleging deficiencies in access to intensive community-based mental health services" for children/youth enrolled in Medicaid. Currently an interim agreement has been met and system reforms are forthcoming. The goal is to reduce psychiatric hospitalization, foster care placements and juvenile justice interventions for Medicaid children/youth with mental health issues.

Some of the changes identified in the interim agreement include:

- Washington Individualized Youth Services (WIYS)
  - Access Model that describes access pathways to WIYS
    - One aspect of the Access Model is utilization of the Child and Adolescent Needs and Strengths (CANS) tool for screening and assessment
  - Child and Family Teams

Contract language is supposed to be received regarding these and other related changes prior to October 2012. The most immediate of these changes appears to be Child and Family Teams. The details of how these changes will be implemented is still unclear to NSMHA, but we are expecting changes to several aspects of our system including but perhaps not limited to access, assessment, authorization, and service delivery.

CONCLUSIONS/RECOMMENDATIONS:
We will continue to stay involved with this process and provide updates and direction as quickly as possible.

TIMELINES:

ATTACHMENTS:

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Healthy Options and Health Plan/RSN MOU

PRESENTER: Greg Long

COMMITTEE ACTION: Action Item () FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
Healthy Options is revised managed care plan that has major changes and new health plans which started on July 1, 2012. The five large health plans that are managing this program are as follows:

- AmeriGroup/Well Point,
- Coordinated Care Corporation,
- Community Health Plan of Washington,
- Molina,
- United Health Care managing

The Healthy Options Plans have a limited mental health benefit of 20 sessions for children and 12 sessions for adults. People in Healthy Options also retain their RSN Benefit, but they must meet Access to Care Standards.

All of the RSNs had a series of phone meetings with them and have agreed to sign the attached high level MOU agreements. All of the health plans have agreed to meet with the RSNs in July and August to develop more detailed and RSN specific agreements around access, data sharing, coordination of care, etc.

CONCLUSIONS/RECOMMENDATIONS:
Health Reform is occurring and these are the first among many major changes that will be coming. You do not need to focus on the specifics of these MOU agreements. NSMHA wants everyone to know these agreements are being made.

TIMELINES:

ATTACHMENTS:
Healthy Options Coordinating Agreement
Healthy Options Data Sharing Agreement

JOINT OPERATING AGREEMENT

BETWEEN

_____MANAGED HEALTH CARE ORGANIZATION

AND

_____REGIONAL SUPPORT NETWORK

The Operational Agreement is between the _____a Managed Health Care Organization contracted with the Washington State Health Care Authority to manage Healthy Options and Basic Health Plan(herein after referred to as the **Health Plan**) and the _____Regional Support Network (RSN) contracted with Washington State Division of Behavior Health and Recovery Services to manage a Prepaid Inpatient Health Plan (PIHP)(herein after referred to as the **RSN**) and serves _____ County or _____ region.

I. PURPOSE

This agreement delineates the roles and responsibilities of the **Health Plan** and the **RSN** related to the provision of mental health benefits for their enrollees who are insured under Washington State Medicaid Healthy Options contract and the Washington State Medicaid PIHP contract.

The agreement also demonstrates a shared commitment by both the **Health Plan** and the **RSN** to coordinate care for persons who are involved in or require services from both systems of care.

This agreement is not intended to identify the operational procedures specific to each Health Plan and each RSN. To ensure that both Health Plan and RSN responsibilities are fully met, details of the local procedures and agreements between each Health Plan and each RSN will be provided in an attachment to this Operating Agreement to be completed by **September 01, 2012** (R*eferred to as the Operation Agreement Atta*chment).

II. BACKGROUND

A. Health Plan

The (**Name**) Health Plan provides managed health care services to eligible individuals insured under the Healthy Options Plan in (**Name**) County (ies) (*List counties in the RSN service area covered by the Health Plan*)

B. RSN

The (**Name**) Regional Support Network provides covered mental health services to eligible consumers in **(Name**) County (ies). (*List all counties served by the RSN*)

III. RESPONSIBILITIES AND ROLES

A. Sharing Protected Health Information

The parties agree that information shared under this agreement is shared for the purpose of coordination of treatment and/or health care operations. The parties also agree not to use or disclose protected health information other than as permitted or required by this Agreement, HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The parties shall use and disclose protected health information only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR § 164.504(e).

B. Referrals between the Health Plan and the RSN

While both the **Health Plan** and the **RSN** benefit plans cover medically necessary mental health services the scope of the benefits are distinct. The mental health benefit under the **Health Plan** is a limited benefit. The **RSN** mental health benefit has a broad scope and serves individuals with need for higher intensity and/or specialty mental health services. The Washington State Medicaid Program PIHP requires enrollees to meet both medical necessity and Mental Health Access to Care Criteria to define members' qualification for **RSN** mental health services.

Consumer choices, and/ or person centered care, are essential guiding principles of this agreement. Therefore, enrollees covered under Healthy Options may approach either the **Health Plan** or the **RSN** network providers to request mental health services.

Enrollees who choose to access the **Health Plan** may be referred to the **RSN** by the **Health Plan** providers if it appears that they may meet Access to Care criteria. Enrollees who choose to access an RSN network provider will be assessed and either authorized by the RSN into care or referred to the Health Plan based on PIHP criteria.

1. **RSN** Responsibility

    a. The **RSN** has the responsibility to provide a face-to-face assessment for any person enrolled in Medicaid who requests an intake to determine if the individual meets medical necessity and Access to Care criteria for **RSN** mental health services. The **RSN** shall accept a referral from the **Health Plan** for a face-to-face assessment when the **Health Plan** believes the individual may meet Access to Care criteria for the **RSN** mental health benefit.
    b. The **RSN** will authorize and serve any individual who meets medical necessity and the Access to Care criteria and chooses to be served by the **RSN** contracted provider.
    c. The **RSN** will refer individuals to the **Health Plan** for mental health benefits when the individual does not meet Access to Care criteria or medical eligibility, or has graduated from RSN services and/or no

longer meets criteria for access to **RSN** services but still may meet medical necessity for the **Health Plan** mental health benefit.

2. **Health Plan** Responsibility

   a. The **Health Plan** has the responsibility to determine if their members meet medical necessity for their mental health benefit or if a referral to the **RSN** for an assessment is warranted. The **Health Plan** is also responsible to provide a mental health benefit for their Healthy Option members who present with medical necessity for mental health services and do not meet the **RSN** PIHP Access to Care criteria.
   b. The **Health Plan** may refer individuals at any time to the **RSN** even if they have been served under the **Health Plan's** mental health benefit to determine if the individual meets Access to Care criteria for **RSN** mental health benefits.

C. Coordination of Care and Care Transitions

The **RSN** and the **Health Plan** have responsibility to assure that enrollees who have multiple needs and make frequent use of the systems of care are provided with quality coordinated care. Specific attention shall also be paid to individuals with co-morbid physical and mental health conditions who are admitted to institutional care for either physical health or mental health conditions. The **RSN** and the **Health Plan** and their respective designees (e.g. care managers, contractors, provider networks) will collaborate on coordination of care for persons who are involved in or require services from both systems of care.

1. **RSN** Responsibility
   a. The **RSN** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the RSN contract with the state Division of Behavioral Health and Recovery Services (DBHR)
   b. The **RSN** shall provide timely information related to psychiatric hospital admission and discharge for **Health Plan** Healthy Options members.
   c. The **RSN** and its designees will collaborate with **Health Plan** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the **RSN** will work with the **Health Plan** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
   d. Additional region specific procedures are provided in the Operational Agreement Attachment.

2. **Health Plan** Responsibility
   a. The **Health Plan** shall participate in the Care Transitions Performance Improvement Plan pursuant to the requirements in the Healthy Options contract with the state Health Care Authority (HCA).
   b. The **Health Plan** shall provide timely information related to medical hospital admission and discharge for **Health Plan** Healthy Options members receiving **RSN** PIHP services.

c. The **Health Plan** and its designees will collaborate with **RSN** care coordination activities for individuals who are identified through the state PRISM system with high risk scores. During the first year of this agreement the **Health Plan** will work with the **RSN** to develop procedures and/or protocols for their collaboration on care coordination for persons who are identified as high risk.
d. Additional region specific procedures are provided in the Operational Agreement Attachment.

D. Communications

1. Each **Health Plan** and each **RSN** will provide contact information for functions that will be coordinated between the **Health Plan** and the **RSN**. The individual contacts provided in the Operation Agreement Attachment will include at minimum:
   a. Referrals
   b. Care Coordination and Care Management
   c. Crisis Services Contacts
   d. Data Sharing
   e. Performance Improvement and Quality Management
   f. Dispute Resolution
   g. Critical Incidents

2. The **Health Plan** and the **RSN** agree to participate in further development of additional guidelines and operational procedures that will enhance the bi-directional care coordination between entities. The areas to be addressed may include, but are not limited to the following:
   a. Referral Procedures
   b. Screening Guidelines
   c. Notification of Admissions to Institutional Care
   d. Care Transitions/Discharge Planning from Institutional Care
   e. Continuing Care Transitions
   f. Care Management and Coordination
   g. Performance Measures and Improvement Processes
   h. Notifications of Emergent Care
   i. Data Sharing
   j. Dispute Resolution
   k. Notification of Critical Incidents

IV. Hold Harmless

1. Regardless of any verbal statements made prior to or following signature on this Agreement, nothing in this Agreement is intended to establish a legally binding agreement between the parties.

2. The parties of this agreement will hold one another including their contractors, employees, interns and volunteers harmless for failure to perform any of the roles identified above, including termination of this Agreement with or without advance notice.
3. There shall be no remedy available to one party for failure to perform any role identified above by the other party, or a third party.

V. Dispute Resolution

1. All disputes occurring between the parties of this agreement shall be resolved through informal negotiation between the parties of the Agreement. A guiding principle for resolving disputes is that resolution should be sought at the lowest level and only progress up the hierarchy when satisfactory resolution has not been achieved.
2. Failure to resolve disputes may result in termination of the Agreement.

VI. Term and Termination

1. The effective date of this Agreement will be upon the final signature of the parties to this Agreement and it shall remain in effect until it is terminated in accordance with the terms of this Agreement.
2. Any of the parties to this Agreement may withdraw and terminate their participation from this Agreement for any reason and at any time upon thirty (30) days written notice to the other party. Such notice and other correspondence related to this Agreement should be sent to the contacts and addresses listed above.

VII. Amendment

This Agreement may be amended at any time by written agreement and signature of all the parties.

IN WITNESS WHEREOF, the parties hereto have caused this OA to be executed by the dates and signatures herein under affixed. The persons signing this OA on behalf of the parties represent that each has authority to execute the OA on behalf of the party entering this OA.

_____	_____
RSN Administrator	Executive Director
_____	_____
Date	Date

Healthy Options/RSN Data Needs

June 25th, 2012

DRAFT

RSN to HO Plan (MCO)

Information about plan members being served by the RSN

Admission Notification (Hospitals and E & Ts):

- Name — Last, First and Middle
- DOB — Yes
- ID Number — Provider One ID #
- Admit Date — Yes
- Facility — Name of the Facility or RUID (state reporting unit ID #)
- Diagnosis — Admitting Primary & Secondary if available
- Target d/c date — Not known at admission
- Legal Status — Yes legal status at admission
- RSN Contact — Will provide primary contact (email and phone #)

Discharge Notification (Hospitals and E & Ts):

Uncertain as to whether this is necessary. The RSN is responsible for DC planning and post-DC follow-up. The plans have already been notified of the hospitalization for integrated care.

- Name — Yes
- DOB — Yes
- ID Number — Provider One ID #
- Admit Date — Yes
- Facility — Name of the Facility or RUID(state reporting unit ID #)
- Diagnosis — No—May not have for some period of time
- Discharge Date — Yes
- Client Phone # — If available
- Email — If available
- F/U appointment — No
- F/U provider — No—Possible for those in active treatment
- D/C summary — No—due to time lag of availability of D/C summary
- Access to care criteria met? — If available for those in active treatment—if not in treatment then an assessment would have to be done
- Active in MH TX? Y/N — Yes
- RSN Contact — Will provide primary contact (email and phone #)

Healthy Options/RSN Data Needs

June 25th, 2012

Members in Treatment (at CMHAs): (can be provided if an eligibility file for the plan is provided)

- Name — Yes
- DOB — Yes
- ID Number — Provider One ID #
- Address/phone/email — If available
- Diagnosis — Yes
- Treating Provider — Community Mental Health Agency
- Type of Service — May be problematic
- RSN Contact — Will provide primary contact (email and phone #)
- Treatment Plan: (meds, services, unmet physical health care needs, etc)
  Huge data set—so heavy manpower requirement.
  Suggest handling it on a one off basis for high risk individuals
- Medications — No—do not have information for all individuals/or all meds
- Indicator of which patients had a 7 day follow up contact
  Discussion on how used as this is an RSN requirement already
- Over/under utilization patterns (ER, narcotics, etc)
  Plans have access to this data thru Prism.

Screened/Doesn't meet RSN Criteria

Uncertain as to what is needed here. Nothing was specified.

Healthy Options/RSN Data Needs

June 25th, 2012

MCO to RSN

This information may not be operationalized in all RSNs.

Medical Utilization

- Name — Yes
- ID Number — Provider One ID #
- DOB — Yes
- PCP — Yes
- Enrollment Date — Yes—please define
- Address, phone — Yes
- Diagnosis(s) — Yes, Medical and Psychiatric
- Lock In Program — What is this??
- ER in past 12 months — Yes—purpose and why
- Inpatient in past 12 months — Medical and Psych
- Physician visits in past 90 days — Yes, Primary care only??
- Meds filled in past 30-90 days — Discuss what kind
- Care Gaps (due for physical, well woman, HgAb1c)
    - o — Please further definition
- Medical Case Manager — Yes and contact information

<u>Referral to RSN</u>

Uncertain as to what is needed here. Nothing was specified.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2012 CIRC Process Update
PRESENTER: Kurt Aemmer
COMMITTEE ACTION: **Action Item () FYI & Discussion (x) FYI only ()**

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

A. DBHR has advised the RSNs that the new contract will require the revisions reflected on the attached Critical incident Reporting Form(s)
    1. The revised contract language was not finalized until about 2 weeks ago.
    2. I was not made aware that DBHR will require that the changes must be implemented by July 1 until 8 days ago.
    3. The new contract language requires some significant changes in the RSN reporting process. However, changes to the provider reporting process are limited, primarily involving the addition of a couple categories, discontinuation of a couple categories, and consolidation of others. Plus, there are a couple information items that will now be require of provider and NSMHA reporters.

CONCLUSIONS/RECOMMENDATIONS:

A. NSMHA recognizes that the planning & implementation time allowed by DBHR is unreasonably short, and we are asking the support of the providers to implement them by July 1, 2012… next week.
B. In the mean time, a brief orientation to the attached updated reporting form should suffice for implementation purposes.
C. Revision of the updated CIRC P&P is a work in progress, and will be provided for discussion & approval at the July QMOC.

TIMELINES:

A. New form will be in effect on July 1, 2012
B. Updated P&P will be presented for discussion at July QMOC.

ATTACHMENTS:

1. *Revised Critical Incident Report with track changes*
2. *Revised Critical Incident Report without track changes*
3. *Updated Policy 1009.00*

~~North Sound Mental Health Administration~~

NORTH SOUND MENTAL HEALTH ADMINISTRATION]CRITICAL INCIDENT REPORT

To:	Fax Number	FYI – Telephone Numbers
NSMHA	360-428-1068	800-684-3555 or 360-416-7013

Note: Faxed reports must include cover sheet with confidentiality disclosure.

From: (Print name & credentials of staff completing form) _____

Signature of staff completing form: _____

Telephone: _____ **E-mail if Applicable:** _____

Agency: ☐Compass Health Sno. Co. ☐Compass Health Skagit Co. ☐ Compass Health San Juan Co. ☐ Compass Health Island Co.
☐ North Sound E&T ☐ Snohomish Co. E&T ☐ LWC, clinic ☐ LWC, residential ☐ Bridgeways ☐ SEA MAR Sno Co.
☐ SEA MAR Whatcom Co. ☐ SEA MAR Skagit Co. ☐ Snohomish Co ITA ☐ VOA ☐ WCPC ☐ CCS Sno Co. ☐ CCS Skagit Co.
☐ CCS Whatcom Co. ☐ Interfaith ☐ Sunrise Sno. Co. ☐ Sunrise Skagit Co.

Location (city)of Incident: _____ County of Incident: _____

Consumer Name: _____ DOB: _____ Age: _____ Consumer ID: _____

Date & Time of Incident: _____ Date & Time Incident Known: _____

Date & Time of Report: _____

CHECK ONE ~~TYPE~~ CATEGORY OF INCIDENT IN TYPE I, II or III ~~(non-DSHS) OR TYPE II (DSHS-REPORTABLE),~~ NOT BOTH:

~~Non-DSHS Reportable Critical Incident~~

Note: For all incident categories: (Need for formal internal review is determined by provider or CIRC. Forward findings to NSMHA)~~Incident Type (Requires formal review by provider unless waived by CIRC. Forward findings to NSMHA)~~

Category I:

☐ Unauthorized leave of any non-offender consumer from an E&T: ***This category is reported to NSMHA for regional quality improvement data gathering for follow-up on quality improvement activities, and will not generally be forwarded to DSHS***

☐ Death or serious injury of consumer, staff, or public citizen: ***Only report deaths and serious injuries that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies. Serious injuries include any permanent injury, or one that requires admission to a hospital***

☐ Unauthorized leave (UL) of a mentally ill offender or sexually violent offender: ***Only report incidents where a UL involves a mentally ill offender or a sexually violent offender, and occurs from a Mental Health Facility, or a Secure Community Transition Facility, which includes Evaluation and Treatment Centers (E&T) or a Crisis Stabilization Units (CSU) and Triage Facilities that accept involuntary consumers.***

☐ Violent act: ***Any alleged or substantiated non-fatal injuries, rape, sexual assault, homicide, attempted homicide, arson, or substantial property damage (> $100,000.00), committed by a consumer***

Category II:

☐ Alleged consumer abuse or neglect of a serious or emergent nature: ***The willful action or inaction that inflicts injury, unreasonable confinement, intimidation, punishment on, or abandonment of a vulnerable adult by a DSHS employee, volunteer, licensee, contractor, or another consumer. In an instance of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish***

☐ A substantial threat to facility operation or client safety resulting from a natural disaster (to include earthquake, volcanic eruption, tsunami, fire, flood, and outbreak of communicable disease, etc.)

☐ Any breach or loss of client data in any form that is considered as reportable in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of client personal information. **In addition to the standard elements of an incident report, the entity reporting the CI will document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the client information.**

☐ Allegation of financial exploitation (FE) involving an agency, a consumer or other: ***The illegal or improper use of the property, income, resources or trust funds of the vulnerable adult by any person for any person's profit or advantage other than for the vulnerable adult's profit or advantage***

☐ Suicide attempt requiring medical care: ***Only report suicides attempts that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies & require medical care***

☐ ~~Incident~~Any event involving a consumer or staff ~~reported by the media, or having potential for media interest~~likely to attract media attention

☐ Any event involving: a credible threat towards a staff member that occurs at a DSHS facility, a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. *A credible threat towards staff is defined as "A communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family, which resulted in a report to Law Enforcement, a Restraining/Protection order, or a workplace safety/personal protection plan.*

☐ Any incident that was referred to the Medicaid Fraud Control Unit by the RSN or its SubContractor.

☐ A life safety event that requires an evacuation or that is a substantial disruption to the facility.

Category III:

Formatted: Font: Bold

Formatted: Centered

Formatted: Centered

Formatted Table

Formatted: Normal, Indent: Left: 0", First line: 0"

Formatted: Font: 10 pt

Formatted: Font: 10 pt, Bold

Formatted: Font: 10 pt

Formatted: Font: 10 pt, Italic

Formatted: Font: 10 pt

Formatted: Font: 10 pt

~~**Others notified (check all that apply)** ☐ DMHP ☐ Emergency Medical Services ☐ CPS/APS ☐ Volunteers of America ☐ Provider Executive Director ☐ Provider Clinical Director ☐ Primary Clinician ☐ Provider Quality Manager ☐ Provider Prescriber ☐ Local Law Enforcement ☐ Washington State Patrol~~

~~**I. DSHS Reportable Critical Incident**~~

~~**Incident Type: (Requires formal review by provider unless waived by CIRC. Forward findings to NSMHA)**~~
☐ ~~Death or serious injury of consumer, staff, or public citizen: *Only report deaths and serious injuries that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies. Serious injuries include any permanent injury, or one that requires admission to a hospital*~~
☐ ~~Unauthorized leave (UL) of a mentally ill offender or sexually violent offender: *Only report incidents where a UL involves a designated offender, and occurs from a Mental Health Facility, or a Secure Community Transition Facility, which includes Evaluation and Treatment Centers (E&T) or a Crisis Stabilization Units (CSU)*~~
☐ ~~Alleged consumer abuse or neglect of a serious or emergent nature: *The willful action or inaction that inflicts injury, unreasonable confinement, intimidation, punishment on, or abandonment of a vulnerable adult by a DSHS employee, volunteer, licensee, contractor, or another consumer. In an instance of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish*~~
☐ ~~Assault of a consumer by a staff~~
☐ ~~Assault of a staff by a consumer resulting in hospitalization~~
☐ ~~Suicide attempt requiring medical care: *Only report suicides attempts that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies & require medical care*~~
~~**Incident Type: (Need for formal internal review is determined by provider or CIRC. Forward findings to NSMHA)**~~
☐ ~~Violent act: *Any alleged or substantiated non-fatal injuries, rape, sexual assault, homicide, attempted homicide, arson, or substantial property damage (> $100,000.00), committed by a consumer*~~
☐ ~~Allegation of financial exploitation (FE) involving an agency, a consumer or other: *The illegal or improper use of the property, income, resources or trust funds of the vulnerable adult by any person for any person's profit or advantage other than for the vulnerable adult's profit or advantage*~~
☐ ~~Incident involving a consumer or staff reported by the media, or having potential for media interest~~
☐ ~~Crime involving a consumer or staff reported by the media, or having potential for media interest~~
☐ ~~Natural disaster: *Only report those presenting substantial threat to facility operation or client safety. These may include earthquake, volcano eruption, tsunami, urban fire, flood, an outbreak of communicable disease, etc*~~
☐ ~~Breach of consumer information: *Any breach or loss of consumer data in any form which would allow for the unauthorized use of consumer information*~~

Others notified (check all that apply) ☐ DMHP ☐ Emergency Medical Services ☐ CPS/APS ☐ Volunteers of America ☐ Provider Executive Director ☐ Provider Clinical Director ☐ Primary Clinician ☐ Provider Quality Manager ☐ Provider Prescriber ☐ Local Law Enforcement ☐ Medicaid Fraud Control ☐ Washington State Patrol

COORDINATED QUALITY IMPROVEMENT DOCUMENT

This is a protected Coordinated Quality Improvement document solely for the purpose of assuring Continuous Quality Improvement, and Quality Assurance by the North Sound Mental Health Administration, its providers and component counties. This document is strictly confidential to the fullest extent allowed by RCW 43.70.10 and is not subject to disclosure pursuant to Chapter 43.17 RCW.

~~**Others notified (check all that apply)**~~ ☐ ~~-DMHP-~~☐ ~~-Emergency Medical Services-~~☐ ~~-CPS/APS-~~☐ ~~-Volunteers of America~~ ☐ ~~-Provider Executive Director~~ ☐ ~~-Provider Clinical Director-~~☐ ~~-Primary Clinician-~~☐ ~~-Provider Quality Manager-~~☐ ~~-Provider Prescriber~~ ☐ ~~-Local Law-Enforcement-~~☐ ~~-Medicaid Fraud Control-~~☐ ~~-Washington State Patrol~~

~~H.~~I. **Describe the incident**: (*Be specific about what happened, to whom, when and where. Include current diagnosis and treatment* ~~*services*~~*history. Include relevant witnesses or additional staff/consumers involved, and any attachments as appropriate.*) ~~DO NOT IDENTIFY NAMES OF PEOPLE INVOLVED OTHER THAN THE CONSUMER ON THIS FORM. WHEN IDENTIFYING INVOLVED INDIVIDUALS, USE TITLES OR RELATIONSHIP TO CONSUMER AND AVOID USING NAMES IF POSSIBLE.~~WHEN YOU INCLUDE THE NAME OF AN INVOLVED INDIVIDUAL OTHER THAN THE CONSUMER, ALSO STATE THEIR TITLE OR RELATIONSHIP TO THE CONSUMER.

~~III.~~II. **Is there essential information you are gathering that is necessary to understanding the critical incident?**

☐ **YES** ☐ **NO** - *If yes, please send addendum information to your Quality Manager within 5 business days.*

~~IV.~~III. **Immediate Action Taken:** *(What was done immediately to lessen or prevent consumer loss or harm?)*

~~V.~~IV. **Future Action:** *(What will be done to decrease the likelihood of this type of incident occurring for this and/or other individuals occurring in the future?)*

Management Reviewer (Signature): _____

Title: _____ Date: _____

Quality Manager (Signature): _____ Date: _____

Internal Review: Are there plans for a formal internal review of this incident? ☐ YES ☐ NO
(If YES, submit written findings to NSMHA within 5 business days of the review.)

NORTH SOUND MENTAL HEALTH ADMINISTRATION CRITICAL INCIDENT REPORT

To:	Fax Number	FYI – Telephone Numbers
NSMHA	360-428-1068	800-684-3555 or 360-416-7013

Note: Faxed reports must include cover sheet with confidentiality disclosure.

From: (Print name & credentials of staff completing form) _____

Signature of staff completing form: _____

Telephone: _____ **E-mail if Applicable:** _____

Agency: ☐ Compass Health Sno. Co. ☐ Compass Health Skagit Co. ☐ Compass Health San Juan Co. ☐ Compass Health Island Co.
☐ North Sound E&T ☐ Snohomish Co. E&T ☐ LWC, clinic ☐ LWC, residential ☐ Bridgeways ☐ SEA MAR Sno Co.
☐ SEA MAR Whatcom Co. ☐ SEA MAR Skagit Co. ☐ Snohomish Co ITA ☐ VOA ☐ WCPC ☐ CCS Sno Co. ☐ CCS Skagit Co.
☐ CCS Whatcom Co. ☐ Interfaith ☐ Sunrise Sno. Co. ☐ Sunrise Skagit Co.

Location (city)of Incident: _____ County of Incident: _____

Consumer Name: _____ DOB: _____ Age: _____ Consumer ID: _____

Date & Time of Incident: _____ Date & Time Incident Known: _____

Date & Time of Report: _____

CHECK NO MORE THAN ONE TYPE OF INCIDENT TYPE IN CATEGORY I, II or III.

Note: For all incident categories: (Need for formal internal review is determined by provider or CIRC. Forward findings to NSMHA)

Category I:

☐ **Death or serious injury of consumer, staff, or public citizen:** ***Only report deaths and serious injuries that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies. Serious injuries include any permanent injury, or one that requires admission to a hospital***

☐ **Unauthorized leave (UL) of a mentally ill offender or sexually violent offender:** ***Only report incidents where a UL involves a mentally ill offender or a sexually violent offender, and occurs from a Mental Health Facility, or a Secure Community Transition Facility, which includes Evaluation and Treatment Centers (E&T) or a Crisis Stabilization Units (CSU) and Triage Facilities that accept involuntary consumers.***

☐ **Violent act:** ***Any alleged or substantiated non-fatal injuries, rape, sexual assault, homicide, attempted homicide, arson, or substantial property damage (> $100,000.00), committed by a consumer***

Category II:

☐ **Alleged consumer abuse or neglect of a serious or emergent nature:** ***The willful action or inaction that inflicts injury, unreasonable confinement, intimidation, punishment on, or abandonment of a vulnerable adult by a DSHS employee, volunteer, licensee, contractor, or another consumer. In an instance of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish***

☐ A substantial threat to facility operation or client safety resulting from a natural disaster (to include earthquake, volcanic eruption, tsunami, fire, flood, and outbreak of communicable disease, etc.)

☐ Any breach or loss of client data in any form that is considered as reportable in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of client personal information. **In addition to the standard elements of an incident report, the entity reporting the CI will document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the client information.**

☐ **Allegation of financial exploitation (FE) involving an agency, a consumer or other:** ***The illegal or improper use of the property, income, resources or trust funds of the vulnerable adult by any person for any person's profit or advantage other than for the vulnerable adult's profit or advantage***

☐ **Suicide attempt requiring medical care:** ***Only report suicides attempts that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies & require medical care***

☐ Any event **involving a consumer or staff likely to attract media attention**

☐ Any event involving: a credible threat towards a staff member that occurs at a DSHS facility, a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. *A credible threat towards staff is defined as "A communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family, which resulted in a report to Law Enforcement, a Restraining/Protection order, or a workplace safety/personal protection plan.*

☐ Any incident that was referred to the Medicaid Fraud Control Unit by the RSN or its Subcontractor.

☐ A life safety event that requires an evacuation or that is a substantial disruption to the facility.

Category III:

☐ **Unauthorized leave of any non-offender consumer from an E&T:** ***This category is reported to NSMHA for regional quality improvement data gathering for follow-up on quality improvement activities, and will not generally be forwarded to DSHS***

Others notified (check all that apply) ☐ DMHP ☐ Emergency Medical Services ☐ CPS/APS ☐ Volunteers of America
☐ Provider Executive Director ☐ Provider Clinical Director ☐ Primary Clinician ☐ Provider Quality Manager ☐ Provider Prescriber
☐ Local Law Enforcement ☐ Medicaid Fraud Control ☐ Washington State Patrol

COORDINATED QUALITY IMPROVEMENT DOCUMENT

This is a protected Coordinated Quality Improvement document solely for the purpose of assuring Continuous Quality Improvement, and Quality Assurance by the North Sound Mental Health Administration, its providers and component counties. This document is strictly confidential to the fullest extent allowed by RCW 43.70.10 and is not subject to disclosure pursuant to Chapter 43.17 RCW.

I. Describe the incident: (*Be specific about what happened, to whom, when and where. Include current diagnosis and treatment history. Include relevant witnesses or additional staff/consumers involved, and any attachments as appropriate.*) WHEN YOU INCLUDE THE NAME OF AN INVOLVED INDIVIDUAL OTHER THAN THE CONSUMER, ALSO STATE THEIR TITLE OR RELATIONSHIP TO THE CONSUMER.

II. Is there essential information you are gathering that is necessary to understanding the critical incident?

☐ **YES** ☐ **NO** - *If yes, please send addendum information to your Quality Manager within 5 business days.*

III. Immediate Action Taken: *(What was done immediately to lessen or prevent consumer loss or harm?)*

IV. **Future Action:** *(What will be done to decrease the likelihood of this type of incident occurring for this and/or other individuals occurring in the future?)*

Management Reviewer (Signature): _____

Title: _____ Date: _____

Quality Manager (Signature): _____ Date: _____

Internal Review: Are there plans for a formal internal review of this incident? ☐ YES ☐ NO
(If YES, submit written findings to NSMHA within 5 business days of the review.)

COORDINATED QUALITY IMPROVEMENT DOCUMENT

This is a protected Coordinated Quality Improvement document solely for the purpose of assuring Continuous Quality Improvement, and Quality Assurance by the North Sound Mental Health Administration, its providers and component counties. This document is strictly confidential to the fullest extent allowed by RCW 43.70.10 and is not subject to disclosure pursuant to Chapter 43.17 RCW.

Effective Date: 2/3/2010; 10/19/2009; 4/28/2008; 6/25/2007; 11/10/2005; 10/9/2003, Motion #03-054
Revised Date: 6/1/2011
Review Date: 6/22/2011

North Sound Mental Health Administration

Section 1000 – Administrative: Critical Incident Reporting and Review Requirements
CIRC Quality Assurance and Improvement Process

Authorizing Source: PIHP Contract; 42CFR482 & 42CFR483
Cancels:
See Also: Approved by: Interim Executive Director Date: 4/4/2012
Providers must have a "policy consistent with" this policy
Responsible Staff: Deputy Director Signature:

POLICY #1009.00

SUBJECT: CRITICAL INCIDENT REPORTING AND REVIEW REQUIREMENTS CRITICAL INCIDENT REVIEW COMMITTEE (CIRC) QUALITY ASSURANCE AND IMPROVEMENT PROCESS

PURPOSE

This policy describes the processes, circumstances, methods and timelines by which contracted providers in the North Sound Region must provide information to North Sound Mental Health Administration (NSMHA); the processes, circumstances, methods and timelines by which NSMHA must provide information to the Washington State Department of Social and Health Services (DSHS); and, the quality assurance and improvement activities involved regarding reporting and responding to critical incidents (extraordinary occurrences) affecting consumers of NSMHA services and NSMHA providers.

The purpose of the Critical Incident Reporting and Review Requirements and the NSMHA Critical Incident Review Committee (CIRC) quality improvement and assurance process is to:

1. Ensure that, in its ongoing commitment to quality assurance and improvement initiatives, NSMHA promotes consumer safety and risk reduction by requiring the recognition and reporting of extraordinary occurrences. Specifically, NSMHA wants to ensure that:
    a. Care and services delivered meet the requirements of the DSHS/NSMHA and NSMHA/provider contracts, including NSMHA Clinical Eligibility and Care Standards, relevant WACs (Washington Administrative Code), RCWs (Revised Code of Washington) and the CFR (Code of Federal Regulations).
    b. There is a timely and systematic reporting mechanism that promotes appropriate responses to critical incidents/extraordinary occurrences.
2. Provide a framework, structure and set of guidelines for the timely reporting of critical incidents, as defined by DSHS.
3. Support and protect the reporting and documentation of critical incidents under NSMHA's Coordinated Quality Improvement Program (CQIP). NSMHA maintains CQIP status through the Washington State Department of Health for the purpose of improvement of the quality of health care services rendered to consumers and the identification and prevention of medical malpractice as set forth in RCW 43.70.510. NSMHA encourages the development of a system-wide culture, which minimizes individual blame or retribution for involvement in critical incidents and emphasizes accountability, trust, system improvement and continuous learning.
4. To provide quality assurance all documents related to critical incident reporting will contain the following language:

POLICY
NSMHA and its providers are required to report on incidents involving persons who have received services listed below from a NSMHA provider within 365 days of the incident.

1. Outpatient consumers are those who have received an intake assessment and meet eligibility criteria for outpatient services. These individuals are considered outpatient consumers until their case has been officially closed.
2. Crisis Services consumers are currently being served by Crisis Services personnel, and remain so until their case has been closed and/or they have begun receiving outpatient services.
3. Jail Mental Health Services consumers are those who have received an initial assessment and meet eligibility criteria for Jail Mental Health Services, and remain so up to 90 days post-release, and/or they have begun outpatient services as described above.

Note: By definition, a precipitating event that causes an individual to seek any of the above services should not be considered a reportable critical incident as it occurred prior to that individual having received any of the above services. An exception to this rule would be where an individual had received services during a previous treatment episode that occurred within the 365 days prior to the incident. DSHS may also investigate or may require the CIRC to investigate incidents that involve clients who have received services from the Providers more than 365 days prior to the incident.

The following are the categories of critical incidents that must be reported to NSMHA. *Reporting guidelines and/or operational definitions are in italics*:

CATEGORY I Incidents:

1. **Death or serious injury of consumer, staff, or public citizen:** *Only report deaths and serious injuries that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies. Serious injuries include any permanent injury, or one that requires admission to a hospital*
2. **Unauthorized leave (UL) of a mentally ill offender or sexually violent offender:** *Only report incidents where a UL involves a mentally ill offender or a sexually violent offender, and occurs from a Mental Health Facility, or a Secure Community Transition Facility, which includes Evaluation and Treatment Centers (E&T) or a Crisis Stabilization Units (CSU) and Triage Facilities that accept involuntary consumers.*
3. **Violent act:** *Any alleged or substantiated non-fatal injuries, rape, sexual assault, homicide, attempted homicide, arson, or substantial property damage (> $100,000.00), committed by a consumer*

CATEGORY II Incidents:

1. **Alleged consumer abuse or neglect of a serious or emergent nature:** *The willful action or inaction that inflicts injury, unreasonable confinement, intimidation, punishment on, or abandonment of a vulnerable adult by an employee, volunteer, licensee, contractor, or another consumer. In an instance of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish.*
2. **A substantial threat to facility operation or consumer safety resulting from a natural disaster.** *These may include earthquake, volcano eruption, tsunami, fire, flood, an outbreak of communicable disease, etc.*
3. **Any breach or loss of client data in any form that is considered as reportable in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of consumer personal information.** *In addition to the standard elements of an incident report, the provider and NSMHA incident reporter will document and/or attach: 1) the Police report (when information is stolen), 2) any equipment that was lost, and 3) specifics of the consumer information.* A letter of notification shall be sent to each individual whose information was breached. This notification shall occur without unreasonable delay and in no case later than 60 days after discovery of the breach. **Allegation of financial exploitation (FE) involving an agency, a consumer or other:** *The illegal or improper use of the property, income, resources or trust funds of a vulnerable adult by any person for any person's profit or advantage other than for the*

vulnerable adult's profit or advantage. When any allegation of financial exploitation or Medicaid fraud is reported, NSMHA Designated Incident Reporter*(DIR) shall notify the Medicaid Chief Criminal Investigator (CCI), and then forward a copy of the DSHS report to the CCI.*

4. **Suicide attempt requiring medical care:** *Only report suicide attempts that occur at a DSHS facility, or a facility that DSHS licenses, contracts with, and certifies, and require care from a physician.*
5. **Any event involving a consumer or staff likely to attract media attention.**
6. **Any event involving: a credible threat towards a staff member that occurs at a DSHS facility, a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community.** *A credible threat towards staff is defined as "A communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member's family, which resulted in a report to Law Enforcement, a Restraining/Protection order, or a workplace safety/personal protection plan.*
7. **Any incident that was referred to the Medicaid Fraud Control Unit by NSMHA or its sub-contractor.**
8. **A life safety event that requires an evacuation or that is a substantial disruption to the facility.**

Note: In addition to the categories described above, the DIR will utilize professional judgment and report incidents that fall outside the scope of this section.

CATEGORY III Incident:

1. **UL of any non-offender consumer from an E&T.**

PROCEDURE: Critical Incident Reporting:

1. Providers fax the completed NSMHA Critical Incident Form (available online at http://www.nsmha.org/forms/index.asp) to NSMHA.
2. The NSMHA DIR, or designated back-up Quality Specialist will utilize the DSHS electronic incident reporting system. (If/when the electronic incident reporting system is unavailable for use, the DIR will complete a DSHS standardized form, and attach it to an encrypted email addressed to the DSHS incident manager.
   a. **CATEGORY I Incidents:** Providers shall report and also notify the NSMHA DIR by telephone or email immediately upon becoming aware of the occurrence of any of the following Category I incidents. In turn, the DIR must also notify DSHS by telephone or email immediately upon becoming aware of the occurrence:
   b. **CATEGORY II Incidents:** Providers shall report any of the following Category II incidents to the NSMHA DIR by encrypted email or fax within one working day of becoming aware of the occurrence of any of the following Category II incidents. In turn, the DIR must report any of the following Category II incidents to DSHS within one working day of becoming aware of the occurrence of any of the following Category II incidents.
   c. **CATEGORY III Incident:** Follow the same reporting guidelines as Category II Incidents. However, **t**his category is reported to NSMHA for regional quality improvement data gathering, as follow-up on quality improvement activities, and will not generally be forwarded to DSHS unless there is media involvement.
3. All reports must contain the following:
   a. A description of the incident;
   b. Date and time of the incident;
   c. Incident location (city if known, county if city is not known);
   d. Incident type;
   e. Names and ages, if known, of all individuals involved in the incident;
   f. Nature of each individual's involvement in the incident;
   g. Service history with the Contractor, if any, of individuals involved;
   h. Steps taken by the provider to minimize further loss or harm; and
   i. Any legally required notifications made by the Contractor.

4. Submit any additional information necessary to understanding the incident to NSMHA via fax or encrypted email as it becomes known.
5. Additionally, the provider ensures that all plans for corrective action following a review or investigation are implemented for quality assurance and improvement and incorporated into all administrative areas as necessary for quality assurance and improvement.
6. The NSMHA DIR tracks all reported critical incidents, maintains a log, database and timeline, and writes any follow-up reports required. In some instances, the DIR initiates region-wide quality improvement activities related to an incident or group of incidents.
7. Additional reporting and review requirements for DSHS reportable critical incidents for the NSMHA DIR:
    a. Notifies County Coordinators, NSMHA Board Chair via a blinded copy of the DSHS critical incident report, and NSMHA Executive Director with an unblinded copy. Notification shall occur within one (1) business day of NSMHA's receipt of the provider critical incident report.

Critical Incident Investigation Requirements & Quality Improvement Process

1. DSHS may require the DIR to report and initiate an investigation that has not yet been reported by a NSMHA provider.
2. The DIR will fully cooperate with any investigation initiated by DSHS and provide any information requested by DSHS within the timeframes specified within the request.
    a. If the DIR does not respond according to the timeframe in DSHS's request, DSHS may obtain information directly from any involved party and request their assistance in the investigation.
    b. DSHS may request medication management information.
    c. DSHS also may investigate or may require the CIRC to investigate incidents that involved consumers who have received services from NSMHA providers more than 365 days prior to the incident.

3. NSMHA maintains a Critical Incident Review Committee (CIRC) whose purpose is to review all critical incidents submitted. The NSMHA CIRC membership will include a NSMHA Clinical Oversight Quality Specialist with expertise in adult services who serves as the DIR, a NSMHA Clinical Oversight Quality Specialist with expertise in child/youth services, a non-clinical NSMHA staff member, and a NSMHA support staff member. The NSMHA Medical Director shall consult as requested in manners pertaining to medical/psychiatric matters when requested. The CIRC will meet regularly to review all critical incident reports, request written follow-up reports from providers, investigate critical incidents utilizing internal selective reviews and make quality improvement recommendations related to critical incidents to the NSMHA Quality Management Oversight Committee, the NSMHA Leadership Team, &/or the Clinical Oversight Team for further appropriate action.
4. During the regularly scheduled CIRC meeting, the DIR shall facilitate review and discussion of each new critical incident and critical incidents from previous months on which the committee determined further review was required before proper disposition of the case could be determined.
5. During a CIRC review, the committee members shall address each incident in the following context:

    a. Does the description of the critical incident and/or subsequent information warrant concern about quality or appropriateness of care delivered by the provider?
    b. Does the incident report indicate that appropriate action was taken immediately after the incident to lessen or prevent consumer loss or harm?
    c. Does the incident report indicate that an appropriate plan for future action has been made to decrease the likelihood of this type of incident occurring again?
    d. Can/should any further action be pursued by NSMHA or the provider?

6. When the CIRC members reach a consensus that the critical incident report and any follow-up information answer the preceding questions satisfactorily, the incident is considered "closed."
7. NSMHA may deem further action is warranted in the case of a particular critical incident or group of incidents. Actions may include but are not limited to:

a. NSMHA selective review
b. Request for provider internal case review
c. Request for parts of or complete medical records
d. Request for special meetings or quality initiatives (e.g., Root Cause Analysis) regarding quality concerns involved
e. Request for provider initiated quality assurance and improvement activities based on incidents or groups or types of incidents
f. Other requests as deemed necessary

8. Incident Review and Follow-up**:** CIRC will review and follow-up on all incidents reported. CIRC will provide sufficient information, review, and follow-up to take the process and report to its completion. An incident will not be categorized by DSHS as complete until the following information is provided:
    a. Summary of any incident debriefings or review process dispositions;
    b. Present physical location of the consumer if known. If the consumer cannot be located, the DIR will document in the incident reporting system the steps that the Contractor took to attempt to locate the consumer by using available local resources;
    c. Documentation of whether the consumer is receiving or not receiving mental health services from the provider at the time the incident is being closed;
    d. In the case of a death of the consumer, the provider must provide either a telephonic verification from an official source or via a death certificate.
        - In the case of a telephonic verification, the provider will document the date of the contact and both the name and official duty title of the person verifying the information.
        - If this information is unavailable, the attempt to retrieve it will be documented.

    e. Actions taken as a result of the occurrence, results of said actions, additional actions that are planned in the future and efforts that have been undertaken designed to lessen the potential for recurrence shall be reported to CIRC within 21 days of becoming available.

9. CIRC will develop a semi-annual summary report and data analysis each July and January. Copies of the semi-annual report will be distributed &/or presented to NSMHA Board of Directors, NSMHA Advisory Board, NSMHA Quality Management Oversight Committee (QMOC) and County Coordinators.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Current and future contract changes

PRESENTER: Greg Long

COMMITTEE ACTION: Action Item () FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

DBHR has made a number of contract changes effective July 1, 2012 and they will be issuing further contract changes which will be effective October 1, 2012. People need to be aware of the current changes and NSMHA will alert you to future changes as they become clear. NSMHA's plan is to make one set of contract changes in late September or October with providers.

Current contract changes which people need to be aware of that became effective July 1, 2012 include:

- Critical Incident Policy Changes (Discussed elsewhere in this meeting.)
- Washington State Children's Mental Health System Principles and Core Practice Model
- Maintain the ability to provide an intake evaluation and services at an Enrollee's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to persons discharged from a state hospital or evaluation & treatment facilities to such placements when the Enrollee requires an on-site service due to medical needs or lack of transportation.
- Maintain the ability to adjust the number, mix, and geographic distribution of MHCPs to meet Access and Distance Standards as the population or Enrollees needing mental health services shift within the service area.
- Maintain the ability to adjust reimbursement amounts for different specialties or for different practitioners in the same specialty to meet Access and Distance Standards as the needs of the Enrollees shift within the service area.
- Increase emphasis and greater accountability regarding Performance Measures
- In the event that shorter timelines for implementation of changes under this section are required or necessitated by either a court order or agreement resulting from a lawsuit or legislative action, DBHR will provide as much notice as possible of the impending changes and provide specifications for the changes as soon as they are available.
- If an Enrollee is a Tribal Member and is referred to or presents for non-crisis services and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in treatment planning and service provision for the Enrollee. If the Enrollee chooses to be served only by the Tribal Mental Health Service referral to a contracted network CMHA is not required.
- 17.6.9. Report suspected fraud, waste, abuse or neglect directly to the Medicaid Fraud Control Unit (MFCU) as soon as it is discovered and cooperate in any investigation or prosecution conducted by the MFCU. Report information sent to the MFCU to DBHR within one (1) working day, to include the source of the complaint, the involved CMHA,

the nature of the suspected fraud, waste, abuse or neglect, the approximate dollars involved, and the legal and administrative disposition of the case.

CONCLUSIONS/RECOMMENDATIONS:
TIMELINES:
These are incremental changes that DBHR is making and are covered in part in the existing contracts. There are similar and parallel changes to the State Mental Health Contracts.

ATTACHMENTS:
PIHP Contract Amendments

Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES	**CONTRACT AMENDMENT** **PIHP Amendment**	DSHS CONTRACT NUMBER: 1169-36766 Amendment No. 02

This Contract Amendment is between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below.	Program Contract Number Contractor Contract Number

CONTRACTOR NAME	CONTRACTOR doing business as (DBA)	
North Sound Regional Support Network		
CONTRACTOR ADDRESS	**WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)**	**DSHS INDEX NUMBER**
117 North First Street, Suite 8 Mount Vernon, WA 98273-2858	601-291-840	1553

CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR FAX	CONTRACTOR E-MAIL ADDRESS
Joe Valentine	(360) 416-7013		joe_valentine@nsmha.org

DSHS ADMINISTRATION	DSHS DIVISION	DSHS CONTRACT CODE
Aging and Disability Services Administration	Division of Behavioral Health and Recovery	1684LS-69

DSHS CONTACT NAME AND TITLE	DSHS CONTACT ADDRESS
Travis Sugarman Contracts Administrator	4500 10th Avenue SE Lacey, WA 98503

DSHS CONTACT TELEPHONE	DSHS CONTACT FAX	DSHS CONTACT E-MAIL ADDRESS
(360) 725-2042	(360) 586-9727	sugarts@dshs.wa.gov

IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT?	CFDA NUMBERS
No	

AMENDMENT START DATE	**CONTRACT END DATE**
07/01/2012	09/30/2013

PRIOR MAXIMUM CONTRACT AMOUNT	AMOUNT OF INCREASE OR DECREASE	TOTAL MAXIMUM CONTRACT AMOUNT
$0.00	$0.00	$0.00

REASON FOR AMENDMENT;
CHANGE OR CORRECT CONTRACT TERMS OR SOW, SEE PAGE TWO

ATTACHMENTS. When the box below is marked with an X, the following Exhibits are attached and are incorporated into this Contract Amendment by reference:

☒ Additional Exhibits (specify): Revised Exhibit D – Rates Table; Exhibit F - Washington State Children's Mental Health System Principles and Core Practice Model

This Contract Amendment, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties as changes to the original Contract. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract Amendment shall be deemed to exist or bind the parties. All other terms and conditions of the original Contract remain in full force and effect. The parties signing below warrant that they have read and understand this Contract Amendment, and have authority to enter into this Contract Amendment.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

DSHS SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
	ADSA DBHR Contracts Office	

This Contract between the State of Washington Department of Social and Health Services (DSHS) and the Contractor is hereby amended as follows:

Insert Revised Exhibit D, as shown on Page 10.

Revise Section 3, to read as follows:

3. INCIDENTS:

3.1. The Contractor must have a designated incident manager responsible for meeting the requirements under this section. The Contractor must maintain policies and procedures regarding mandatory incident reporting and referrals consistent with all applicable state and federal laws. The policy must address the Contractor's oversight and review of the requirements in this section.

3.2. Reporting

3.2.1. For individuals served by the Contractor within 365 days of an incident, the Contractor must report and follow-up on the incident.

3.2.2. The Contractor must report incidents using DBHR's electronic incident reporting system. If the electronic incident reporting system is unavailable for use, a DBHR standardized form shall be provided with instructions.

3.2.3. The report must contain:

3.2.3.1. A description of the incident;

3.2.3.2. the date and time of the incident;

3.2.3.3. incident location;

3.2.3.4. incident type;

3.2.3.5. names and ages, if known, of all individuals involved in the incident;

3.2.3.6. the nature of each individual's involvement in the incident;

3.2.3.7. the service history with the Contractor, if any, of individuals involved;

3.2.3.8. steps taken by the Contractor to minimize harm; and

3.2.3.9. any legally required notifications made by the Contractor.

3.2.4. The Contractor must report the following incidents. In addition, the Contractor shall use professional judgment in reporting incidents not listed herein.

3.2.4.1. Category One Incidents: the Contractor must report and also notify the DBHR Incident Manager by telephone or email immediately upon becoming aware of the occurrence of any of the following Category One incidents.

3.2.4.1.1. Death or serious injury of patients, clients, staff, or public citizens at a DSHS facility or a facility that DSHS licenses, contracts with, or certifies.

3.2.4.1.2. Unauthorized leave of a mentally ill offender or a sexual violent offender from a mental health facility or a Secure Community Transition Facility. This includes Evaluation and Treatment centers (E&T) Crises Stabilization Units (CSU) and Triage Facilities that accept involuntary clients.

3.2.4.1.3. Any violent act to include rape or sexual assault, as defined in RCW 71.05.020 and RCW 9.94A.030, or any homicide or attempted homicide committed by a client.

3.2.4.2. Category Two Incidents: the Contractor must report within one (1) working day of becoming aware that any of the following Category Two Incidents has occurred:

3.2.4.2.1. Alleged client abuse or client neglect of a serious or emergent nature by an employee, volunteer, licensee, Contractor, or another client.

3.2.4.2.2. A substantial threat to facility operation or client safety resulting from a natural disaster (to include earthquake, volcanic eruption, tsunami, fire, flood, an outbreak of communicable disease, etc.).

3.2.4.2.3. Any breach or loss of client data in any form that is considered as reportable in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act and that would allow for the unauthorized use of client personal information. In addition to the standard elements of an incident report, RSNs will document and/or attach: 1) the Police report, 2) any equipment that was lost, and 3) specifics of the client information.

3.2.4.2.4. Any allegation of financial exploitation as defined in RCW 74.34.020.

3.2.4.2.5. Any attempted suicide that requires medical care that occurs at a facility that DSHS licenses, contracts with, and/or certifies.

3.2.4.2.6. Any event involving a client or staff likely to attract media attention.

3.2.4.2.7. Any event involving: a credible threat towards a staff member that occurs at a DSHS facility, a facility that DSHS licenses, contracts with, or certifies; or a similar event that occurs within the community. A credible threat towards staff is defined as “A communicated intent (veiled or direct) in either words or actions of intent to cause bodily harm and/or personal property damage to a staff member or a staff member’s family, which resulted in a report to Law Enforcement, a Restraining/Protection order, or a workplace safety/personal protection plan.

3.2.4.2.8. Any incident that was referred to the Medicaid Fraud Control Unit by the RSN or its Sub Contractor.

3.2.4.2.9. A life safety event that requires an evacuation or that is a substantial disruption to the facility.

3.3. Investigation:

3.3.1. DBHR may require the Contractor to initiate an investigation of an incident.

3.3.2. The Contractor will fully cooperate with any investigation initiated by DSHS and provide any information requested by DSHS within the timeframes specified within the request.

3.3.3. If the Contractor does not respond according to the timeframe in DSHS’ request, DSHS may obtain information directly from any involved party and request their assistance in the investigation.

3.3.4. DSHS may request medication management information.

3.3.5. DSHS may also investigate or may require the Contractor to investigate incidents that involve clients who have received services from the Contractor more than 365 days prior to the incident.

3.4. Incident Review and Follow-up**:** the Contractor will review and follow-up on all incidents reported. The Contractor will provide sufficient information, review, and follow-up to take the process and report to its completion. An incident will not be categorized as complete until the following information is provided:

3.4.1. a summary of any incident debriefings or review process dispositions;

3.4.2. the present physic al location of the client if known. If the client cannot be located, the Contractor will document in the Incident reporting system the steps that the Contractor took to attempt to locate the client by using available local resources;

3.4.3. documentation of whether the client is receiving or not receiving mental health services from the Contractor at the time the incident is being closed.

3.4.4. In the case of a death of the client, the Contractor must provide either a telephonic verification from an official source or via a death certificate.

3.4.4.1. In the case of a telephonic verification, the Contractor will document the date of the contact and both the name and official duty title of the person verifying the information.

3.4.4.2. If this information is unavailable, the attempt to retrieve it will be documented.

Add new Section 6.5.4., to read as follows:

6.5.4 Payments to the Contractor will be made according to the following schedule dates which were published by the Health Care Authority, and will be no later than the second Monday of each month.

RSN Prospective Initial Payment Schedule Per HCA	
July 12	7/9/12
August 12	8/6/12
September 12	9/10/12
October 12	10/8/12
November 12	11/12/12
December 12	12/10/12
January 13	1/7/13
February 13	2/11/13

March 13	3/11/13
April 13	4/8/13
May 13	5/6/13
June 13	6/10/13
July 13	7/8/13
August 13	8/12/13
September 13	9/9/13

Delete Sections 6.14.2. and 13.6. through 13.6.3. due to legislative reductions to b(3) funding.

Add a new Section 7.11.3., to read as follows:

7.11.3 The RSNs shall incorporate and disseminate the Washington State Children's Mental Health System Principles and Core Practice Model as guidelines for providing care to children, youth, and their families as referenced in Exhibit F.

Revise Section 7.12.1., to read as follows:

7.12.1 At a minimum the Contractor shall:

7.12.1.1 Offer an intake evaluation by a MHP within ten (10) working days of an Enrollee request.

7.12.1.2 Maintain the ability to provide an intake evaluation at an Enrollee's residence, including adult family homes, assisted living facilities or skilled nursing facilities, including to persons discharged from a state hospital or evaluation & treatment facilities to such placements when the Enrollee requires an on-site service due to medical needs or lack of transportation.

7.12.1.3 Provide or purchase age, linguistic and culturally competent community mental health services for Enrollees for whom services are medically necessary and clinically appropriate consistent with the Medicaid state plan and the Federal 1915 (b) Mental health Waiver.

7.12.1.4 Maintain the ability to adjust the number, mix, and geographic distribution of MHCPs to meet Access and Distance Standards as the population or Enrollees needing mental health services shift within the service area.

7.12.1.5 Maintain the ability to adjust reimbursement amounts for different specialties or for different practitioners in the same specialty to meet Access and Distance Standards as the needs of the Enrollees shift within the service area.

7.12.1.6 Maintain the ability to provide services to Enrollees in their residence, including adult family homes, assisted living facilities and skilled nursing facilities when required due to medical needs or lack of transportation.

Revise Sections 8.3.3. and 8.3.4., to read as follows:

8.3.3. Core Performance Measures #1: A client must be offered a routine outpatient service within seven (7) days of discharge from a psychiatric inpatient hospital or Evaluation and Treatment (E&T) facility. To measure the outcomes of this requirement, DBHR will measure the number of clients who received a routine outpatient service within seven (7) days divided by the total number of discharges from community psychiatric inpatient hospitals and E&Ts.

8.3.3.1. Performance Expectations: The statewide performance target for this measure is 75%. The baseline will be determined using a 12-month period extending from 10/1/2010 thru 9/30/2011. Monitoring will begin July 1, 2012 and will be measured by DBHR quarterly thereafter. DBHR will provide preliminary status reports to the Contractor monthly. At the end of each measurement period, the Department will provide an official report reflecting the Contractor's performance to date.

8.3.3.2. Incremental Performance Improvement: The Contractor's incremental improvement targets will be established by The Department, and will be based on the Contractor's baseline performance.

8.3.3.2.1. If the Contractor's baseline is between 0% and 44%, the Contractor must achieve a net increase of at least 5 percentage points by the end of the second measurement period and must reach 50% by the fourth measurement period.

8.3.3.2.2 If the Contractor's baseline is between 45% and 49%, the Contractor must reach 50% by the end of the second measurement period.

8.3.3.2.3 Once the Contractor's performance is equal to or greater than 50%, the Contractor must reduce the difference between the performance and the target by 10% at every measurement point.

8.3.4 Accountability: Performance accountability is built upon a series of 3-month measurement points with corresponding performance expectations. If, during any measurement, the Contractor fails to meet performance expectations or improvement rates, the Contract shall enter a succession of administrative phases until all deficiencies have been mitigated.

8.3.4.1 Corrective Action: The first measurement point in which the Contractor fails to meet performance expectations will trigger the Corrective Action Phase in accordance with Section 15, Remedial Actions.

8.3.4.1.1 If the Contractor fails to complete corrective action and meet improvement rates, DBHR may take action under the provision of Section 15, Remedial Actions.

Add new Sections 9.2.4. and 9.2.5., to read as follows:

9.2.4. The Contractor may not delegate its responsibility to contract with a provider network. This does not prohibit an RSN contracted, licensed provider from subcontracting with other appropriately licensed provider so long as the sub-contracting provision of this Agreement are met.

9.2.5 The Contractor shall only contract with licensed service providers for the provision of direct services per RCW 71.24.045 and WAC 388-865-0284. Unless a county is a licensed service provider and the Contractor is contracting for direct services, the Contractor shall not provide RSN funds to a county that is a participant in the RSN Interlocal Agreement without a delegation of duties agreement. The agreement must identify the specific duties from the Contractor's PIHP or State Mental Health contract that are being delegated. The requirements for delegation in Section 9.2, 9.2.1, 9.2.2 and 9.2.3 must be met.

Revise Section 11.1.7., to read as follows:

11.1.7. The Contractor shall implement changes documented in DBHR "Service Encounter Reporting Instructions," the "Data Dictionary," and DBHR "Encounter Data Reporting Guide" within 150 days from the date published. When changes on one document require changes to the other, DSHS shall publish all affected documents concurrently.

In the event that shorter timelines for implementation of changes under this section are required or necessitated by either a court order or agreement resulting from a lawsuit or legislative action, DBHR will provide as much notice as possible of the impending changes and provide specifications for the changes as soon as they are available. The Contractor will implement the changes required by the timeline established in the court order, legal agreement or legislative action. To the extent possible, DBHR will work through its stakeholder groups to implement any change as necessary.

Revise Sections 13.8.3 through 13.8.5., to read as follows:

13.8.3. The Contractor shall coordinate with the Children's Long-term Inpatient Programs (CLIP) Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor shall enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

13.8.4. The Contractor shall integrate all regional assessment and CLIP referral activities, including the following:

13.8.4.1. Create and maintain a local process to assess the needs of children being considered for voluntary admission and coordinate referrals to the CLIP Administration.

13.8.4.2. When a person under age eighteen (18) is committed for 180 days under RCW 71.34, the Contractor must assess the child's needs prior to the admission to the CLIP facility. The Contractor must provide a designee who participates in the CLIP Placement Team assignment of children subject to court-ordered involuntary treatment. A RSN representative will share the community and/or family recommendations for CLIP program assignment of committed adolescents.

13.8.4.3. Assess the needs of juveniles transferred for evaluation purposes by the Juvenile Rehabilitation Administration (JRA), or under RCW 10.77 to the Child Study and Treatment Center (CSTC).

13.8.4.4. Ensure that all required CLIP application materials, including community/family CLIP placement recommendations are submitted to the CLIP Administration prior to consideration of voluntary referrals.

13.8.4.5. The RSN shall provide the legal guardian and youth aged 13 and over with a written copy of the CLIP Administration Appeal Process when the RSN denies a voluntary application for CLIP services.

13.8.5. After CLIP Admission, the Contractor must provide Rehabilitation Case Management, which includes a range of activities by the Contractor's or CMHA's liaison conducted in or with a facility for the direct benefit of the admitted youth. This person is the primary case contact for CLIP programs responsible for managing individual cases from pre-admission through discharge. The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the CLIP treatment team.

13.8.5.1. Review for prior authorization recommendations for short-term/acute hospitalization when it is determined by the CLIP program that this is required.

Add new Section 13.8.6.11., to read as follows:

13.8.6.11. The Contractor shall coordinate with the Department of Social and Health Services-Home and Community Services regional office to support the placement of persons discharged or diverted from state hospitals into HCS placements. In order to accomplish this, the Contractor will:

Whenever possible, prior to referring a person with a diagnosis of dementia for a 90 day commitment to a state hospital:

13.8.6.11.1. Ensure that a request for a CARE assessment is made as soon as possible after admission to a hospital psychiatric unit or Evaluation and Treatment facility in order to initiate placement activities for all persons who might be eligible for long-term care services. HCS has agreed to prioritize requests for CARE assessments for individuals who have been detained to an E&T or in another setting.

13.8.6.11.2 Request and coordinate with HCS, a scheduled CARE assessment for such persons. If the assessment indicates functional and financial eligibility for long-term care services, coordinate efforts with HCS to attempt a community placement prior to referral to the state hospital.

13.8.6.11.3 For individuals (both those being discharged and those being diverted) whose CARE assessments indicate likely functional and financial eligibility for long-term care services:

a) The Contractor will coordinate with HCS placement activities with one entity designated as being responsible for those activities. This designation will be documented in writing and agreed upon by both the Contractor and HCS. Where such designation is not made the responsibility shall be the Contractor's.

b) The responsible entity will establish and coordinate a placement or discharge planning team that includes Contractor staff, HCS assessors, and other community partners, as necessary, to develop a plan of action for finding a safe, sustainable placement.

c) The Contractor will ensure coordination and communication will occur between those participants involved in placement activities as identified by the discharge planning team.

13.8.6.11.4. If a placement has not been found for an individual referred for long-term care services within 30 days, the designated entity will convene a meeting to review the plan and to make adjustments as necessary. Such review meetings will occur at least every 30 days until a placement is affected.

13.8.6.11.5. When individuals being discharged or diverted from state hospitals are placed in a long-term care setting, the Contractor will:

a) Coordinate with HCS and any residential provider to develop a crisis plan to support the placement. The model crisis plan format is available on the DBHR website.

b) When the individual meets access to care criteria, coordinate with HCS and any residential provider in the development of a treatment plan that supports the viability of the HCS placement.

Add new Section 14.3., to read as follows:

14.3. Tribal Coordination

If an Enrollee is a Tribal Member and is referred to or presents for non-crisis services and the Enrollee or their legal representative consents, efforts must be made to notify the Tribal Authority or RAIO to assist in treatment planning and service provision for the Enrollee. If the Enrollee chooses to be served only by the Tribal Mental Health Service referral to a contracted network CMHA is not required.

Revise Section 17.6.9. to read as follows:

17.6.9. Report suspected fraud, waste, abuse or neglect directly to the Medicaid Fraud Control Unit (MFCU) as soon as it is discovered and cooperate in any investigation or prosecution conducted by the MFCU. Report information sent to the MFCU to DBHR within one (1) working day, to include the source of the complaint, the involved CMHA, the nature of the suspected fraud, waste, abuse or neglect, the approximate dollars involved, and the legal and administrative disposition of the case.

All other terms and conditions of this Contract remain in full force and effect.

North Sound RSN

Eligible Rates	**October 2011 to June 2012**	**July 2012 to December 2012**	**January 2013 to June 2013**
Non-Disabled Children	$8.28	$8.28	$xx.xx
Disabled Children	$73.55	$73.55	$xx.xx
Non-Disabled Adults	$11.91	$11.91	$xx.xx
Disabled Adults	$120.72	$120.72	$xxx.xx

b(3) Rates

Eligible Rates	**October 2011 to June 2012**	**July 2012 to June 2013**
Non-Disabled Children	$0.00	$x.xx
Disabled Children	$0.01	$x.xx
Non-Disabled Adults	$0.07	$x.xx
Disabled Adults	$1.23	$x.xx

Local Match Rates

Eligible Rates	**October 2011 to June 2012**	**July 2012 to December 2012**	**January 2013 to June 2013**
Non-Disabled Children	$0.12	$0.12	$x.xx
Disabled Children	$1.05	$1.05	$x.xx
Non-Disabled Adults	$0.17	$0.17	$x.xx
Disabled Adults	$1.73	$1.73	$x.xx

North Sound RSN

WMIP Rate

October 2011- June 2012	
Adults	
Non-Disabled	$10.97
Disabled	$114.30

July 2012- December 2012	
Adults	
Non-Disabled	$10.97
Disabled	$114.30

January 2013 – July 2013	
Adults	
Non-Disabled	$xx.xx
Disabled	$xxx.xx

WA State Children's Mental Health System Principles

RSNs agree to move as quickly as is practicable to develop a Medicaid funded behavioral health system that delivers services according to the Principles set forth below.

- **Family and Youth Voice and Choice**: Family and child voice, choice and preferences are intentionally elicited and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and child-centered from the first contact with or about the family or child.
- **Team based**: Services and supports are planned and delivered through a multi-agency, collaborative teaming approach. Team members are chosen by the family and connected to them through natural, community, and formal support and service relationships. The team works together to develop and implement a plan to address unmet needs and work toward the family's vision.
- **Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships (e.g. friends, neighbors, community and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration**: The system responds effectively to the behavioral health needs of multi-system involved children and their caregivers, including children in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home and Community-based**: Children are first and foremost safely maintained in, or returned to, their own homes. Services and supports strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant**: Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the child/youth and family and their community.
- **Individualized**: Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each child and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths Based**: Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
- **Outcome-based**: Based on the family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are persistent and flexible so as to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional**: A child and family team's commitment to achieving its goals persists regardless of the child's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

CORE PRACTICE MODEL

PURPOSE

The Washington State Division of Behavioral Health and Recovery core practice model is an overarching framework for providing comprehensive behavioral health services and supports for children and youth with complex emotional and behavioral issues. The practice model provides the broad principles that inform and guide the management and delivery of mental health services and supports; describes the treatment and support activities that providers undertake; governs how services are coordinated among systems and providers; prescribes the means to measure and account for outcomes; provides relevant feedback to managers and clinicians so as to continuously improve system and services quality; and ensures cost-effective use of resources.

PRACTICE MODEL COMPONENTS

Practice components embrace wraparound principles employed within a statewide System of Care to the fullest extent feasible. Each individual case affords the child and family all of components 1-6 (below) over the course of treatment and transition.

1. ***Engagement*:** Engaging families is the foundation to building trusting and mutually beneficial relationships between family members, team members, and service providers. Agencies involved with the child and family work to reach agreement about services, safety, well-being (meeting attachment and other developmental needs, health, education, and mental health), and permanency.
2. ***Assessing*:** Information gathering and assessing needs is the practice of gathering and evaluating information about the child and family, which includes gathering and assessing strengths as well as assessing the underlying needs. Assessing also includes determining the capability, willingness, and availability of resources for achieving safety, permanence, and well-being of children.
3. ***Service Planning and Implementation***: Service planning is the practice of tailoring supports and services unique to each child and family to address unmet needs. The plan specifies the goals, roles, strategies, resources, and timeframes for coordinated implementation of supports and services for the child, family, and caregivers.
4. ***Teaming:*** Teaming is a process that brings together individuals agreed upon by the family who are committed to them through informal, formal and community support and service relationships. Where medically necessary and/or with cross system involvement, a formal Child and Family Team will be used.
5. ***Monitoring and Adapting*:** Monitoring and adapting is the practice of evaluating the effectiveness of the plan, assessing circumstances and resources, and reworking the plan as needed. The team is responsible for reassessing the needs, applying knowledge gained through ongoing assessments, and adapting the plan in a timely manner.
6. ***Transition*:** The successful transition away from formal supports can occur as informal supports are in place and providing needed support. Transition to the most normalizing activities and environments is consistent with the principle of treatment at the least restrictive level and the system values of recovery and resilience.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2012 Customer Satisfaction Survey Implementation Plan
PRESENTER: Kurt Aemmer
COMMITTEE ACTION: Action Item () FYI & Discussion (x) FYI only ()
SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

A. NSMHA will be conducting the 2nd Customer Satisfaction Survey in 2012, again during the 3rd & 4th weeks of October, from 10/15/12 through 10/29/12.
    1. The implementation process will be essentially the same as the initial survey conducted in 2011, however implementation will be initiated earlier (8/22 vs. 9/1/) to allow providers an additional week for orientation.
    2. Six different types of survey questionnaires (see attached) will be distributed to each provider, in ample numbers, by August 22, 2012 to allow for providers to reorient their outpatient clinical and office staffs during the month of September, and the first two weeks of October
        a. Adult English
        b. Adult Spanish
        c. Youth English
        d. Youth Spanish
        e. Child/Caregiver English
        f. Child/Caregiver Spanish
    3. Again, only individuals receiving outpatient services will be surveyed
        a. Reception staff will administer the questionnaires for individuals receiving in-office services
        b. Outreach staff will administer questionnaires for individuals receiving services out-of-the office, e.g. at home, jail, etc.
        c. Individuals utilizing only peer centers, residential, &/or crisis services will not be surveyed unless they are receiving the outpatient services delineated above.
        d. Though only receptionist and outreach workers will administer the questionnaires, all clinical staff (including residential staff) will be oriented to the survey so they will be able to provide knowledgeable answers to questions about the survey that may be presented to them by individuals being surveyed.
            i. Note: If an individual initially declines the invitation to complete a questionnaire, but agrees to complete one the next time they receive services during the two-week survey period, a refusal sheet will be placed in the collection envelope to be subsequently replaced by the completed questionnaire when it is returned by the respondent.
    4. Refusal sheets will be included as well. If/when an individual declines a request to complete a questionnaire; a refusal sheet will be placed in the collection envelope. Refusal sheets will be collected with the completed questionnaires, and forwarded to NSMHA with the questionnaires after October 31, 2011. Refusal sheets will allow for subsequent analysis of participation rates.
    5. NSMHA will provide each provider with enough self-addressed, stamped manila envelopes for each of their locations

B. Survey Process
    1. Between October 17- 28, each consumer who checks in at the reception desk for an outpatient treatment session will be asked by a receptionist to take 5 minutes to complete an anonymous questionnaire and return it to the receptionist who will place it in the designated manila envelope. When a consumer refuses to participate, a copy of the refusal sheet will be placed in the envelope.
    2. Before departing on an outreach, staff will be responsible to request a sufficient number of questionnaires and refusal sheets, from the receptionist(s), for all of the consumers they will be visiting that day.
        a. During each outreach, staff will provide consumers with the option to complete a questionnaire, or refuse.

b. On their return to the office, outreach staff will leave the completed questionnaires & refusal sheets with the reception staff.
c. Reception staff will place the completed questionnaires & refusal sheets in the designated manila envelope as described in item #6 a, above.

3. On Thursday November 1, 2011, all envelopes containing the completed questionnaires and refusal cards will be sealed, and mailed to Kurt Aemmer at NSMHA:

   Kurt Aemmer, Quality Specialist
   North Sound Mental Health Administration
   117 North 1st Street, Suite 8
   Mount Vernon, WA 98273-2858

4. During the month of November, Kurt Aemmer will assist Dennis Regan in analyzing the data
5. Given there is no delay in data collection and analysis, Kurt Aemmer will prepare a written report of the findings by Friday, December 21, 2012, and deliver to the NSMHA Leadership Team and QMOC in January, 2013.
6. Data sets will subsequently be provided to each agency, pertaining to their respective consumers for their subsequent analysis.

CONCLUSIONS/RECOMMENDATIONS:

A. As the overall participation rate (#completed questionnaires + # of completed non-participation sheets/# of individuals served in the region during the study period) was only 45.22%, a primary goal for 2012 will be An overall participation rate of >60%, a 15% increase from 2011.

TIMELINES:

A. 6/29/12: Inventory of available questionnaires completed
B. 7/15/12: Replacement questionnaires ordered from vender
C. 8/1/12: Replacement questionnaires received from vender
D. 8/22/12: Adequate # of questionnaires with NSMHA self-addressed stamped envelopes distributed to providers immediately following QMOC
E. 8/22/12 - 10/12/12: QMOC members re-orient clinical & office staff to survey process, and distribute questionnaires & envelopes to all locations
F. 10/15/12 - 10/26/12: Survey is conducted
G. 11/1/12 - All completed & unused questionnaires, & all completed refusal sheets mailed to Kurt Aemmer
H. 12/21/12 – Written report completed

ATTACHMENTS:

1. *6.21.12 CUSTOMER SAT IMPLEMENTATION OUTLINE FOR 7.25 QMOC*

2012 NSMHA
Customer Satisfaction Survey
Implementation Outline
June 21, 2012

Overview:

The North Sound Mental Health Administration (NSMHA) and our providers conduct a wide variety of quality improvement initiatives to try to constantly improve services. Prior to 2011, a missing piece of this effort has been regional consumer satisfaction studies for a number of years.

NSMHA is therefore conducting a simple 15 question survey using questions from two widely used national surveys to collect consumer satisfaction data. This initiative is modeled after one that has been conducted in Clark County RSN for several years, and the 2011 NSMHA Survey.

Implementation Strategy

1. At the 7/25/12 QMOC meeting NSMHA will orient the provider Quality Managers to the survey process.
2. At the 8/22/12 QMOC meeting:
    a. Enough survey questionnaires, for each age group, in separate packets for each provider agency.
        1) Age groups include:
            a) Adults (21+)
            b) Youth (13-20)
            c) Parents/Caregivers (for children up to and including 12)
    b. One self-addressed, oversized manila envelopes for each site.
    c. At least five Refusal/Non-participation sheets, for each age group, for each site.
    d. NOTE: Each Provider Quality Manager will determine how many questionnaires each of their outpatient sites, and distribute them with the envelopes and refusal sheets accordingly.
3. Between Wednesday 8/22/12 & Friday 10/12/12 the Quality Manager for each agency will:
    a. distribute the packets to each of their respective outpatient sites
    b. orient all staff at their outpatient sites to the survey process
        1) **NOTE:** Orientation to *all* receptionists and outreach staff will be critical, as they will be the individuals whose role

will be to offer the questionnaires to the people who will be filling them out, and retrieve the forms once they are completed.

Survey Steps: 10/15/12 – 10/26/12

I. Receptionists
   A. All customer satisfaction questionnaires, refusal sheets, and NSMHA self-addressed envelopes will be kept at the reception desk, at each outpatient site.
   B. When each individual arrives for their outpatient session, the receptionist will inform them (or their caregiver) that a customer satisfaction survey is being conducted throughout the region, and they will be asked to participate, anonymously.
   C. The receptionist will give a questionnaire, appropriate to the participant's age and language groups, and ask the participant to complete it while they are waiting for their session to begin.
      1. The receptionist should inform the individual that there are only 15 questions, and it can be completed in a very few minutes.
   D. If the individual refuses to participate, the receptionist will place an age group appropriate refusal sheet in the NSMHA self-addressed envelope, and return the unused questionnaire to the stack of unused questionnaires at the reception desk
   E. When the individual completes the questionnaire, the receptionist will thank the individual for their participation, and place the completed questionnaire in the NSMHA self-addressed envelope.

II. Outreach Staff
   A. Each day, before embarking on routine outpatient outreach session(s), the outreach staff person will stop by the receptionist's desk and pick up an appropriate number of age/language appropriate questionnaires and refusal sheets.
   B. At each visit, the outreach staff person will ask the consumer to take a few minutes to complete a questionnaire.
   C. If the individual refuses to participate, the outreach staff person will note the consumer's choice not to participate.
   D. On returning to the office, the outreach staff person will hand over all questionnaires and refusal sheets to the receptionist, who will place the completed questionnaires and refusal sheets in the NSMHA self-addressed envelope, and return any unused questionnaires to the stack of unused questionnaires at the reception desk.

III. Receptionists

A. By Thursday 11/1/12 the receptionist will seal the NSMHA self-addressed envelope, containing all of the completed and unused questionnaires, along with the used refusal sheets, and mail them to:
Kurt Aemmer, Quality Specialist
North Sound Mental Health Administration
117 North 1st Street
Mount Vernon, WA 98273-2858

IV. Other Considerations

A. Each site will likely need more than the five refusal sheets provided. Please feel free to make more photocopies of the refusal sheets initially, or when you get down to the last sheet or two.
    1. These sheets are necessary for NSMHA to calculate participation rates, so please use them whenever appropriate
    2. They hold no copyrights, so make and use as many copies as you need to
    3. The originals have color-coded titles, but the colors were primarily used to aid initial collating and distribution. Please feel free to use black & white copies when the colored ones run out.
    4. If the receptionists find that the site is running short of questionnaires, they should follow the steps below:
        a. Call the reception desk of a sister site and request the they share extra copies
        b. If the sister site is also running low and cannot provide extra copies, photocopy the needed number of questionnaires.
        NOTE: Because of copyright obligations pertaining to the questionnaires, please only use photocopies when absolutely necessary.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: 2012 Routine Utilization Review (UR) Results

PRESENTER: Charissa Westergard

COMMITTEE ACTION: Action Item () FYI & Discussion (X) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

NSMHA conducts utilization review annually at provider agencies to determine if individuals are getting the right type and amount of services at the right time. We review standards related to eligibility, treatment planning, coordination of care, whether recovery/resiliency are being incorporated into service delivery, etc. The tool is comprised of 63 standards, which were reviewed at each provider during February-April 2012. The expected benchmark for each standard is 90%.

CONCLUSIONS/RECOMMENDATIONS:

- Providers were above 90% on the vast majority of the 63 standards. All providers aggregate compliance rates were above 90% for 2012 as they were in 2010 and 2011 (see attachment).
- Standard specific deficiencies from the 2012 review are noted by provider (see attachment). This attachment also identifies, which of these standards were also below 90% in 2010 and/or 2011.
- NSMHA will be requesting follow up action for some standards identified as deficient.
- The 2012 tool had some minor revisions from the 2011 tool, but none that significantly impacted monitoring progress since 2011. NSMHA is not anticipating any significant changes for 2013 barring any changes to regulations.

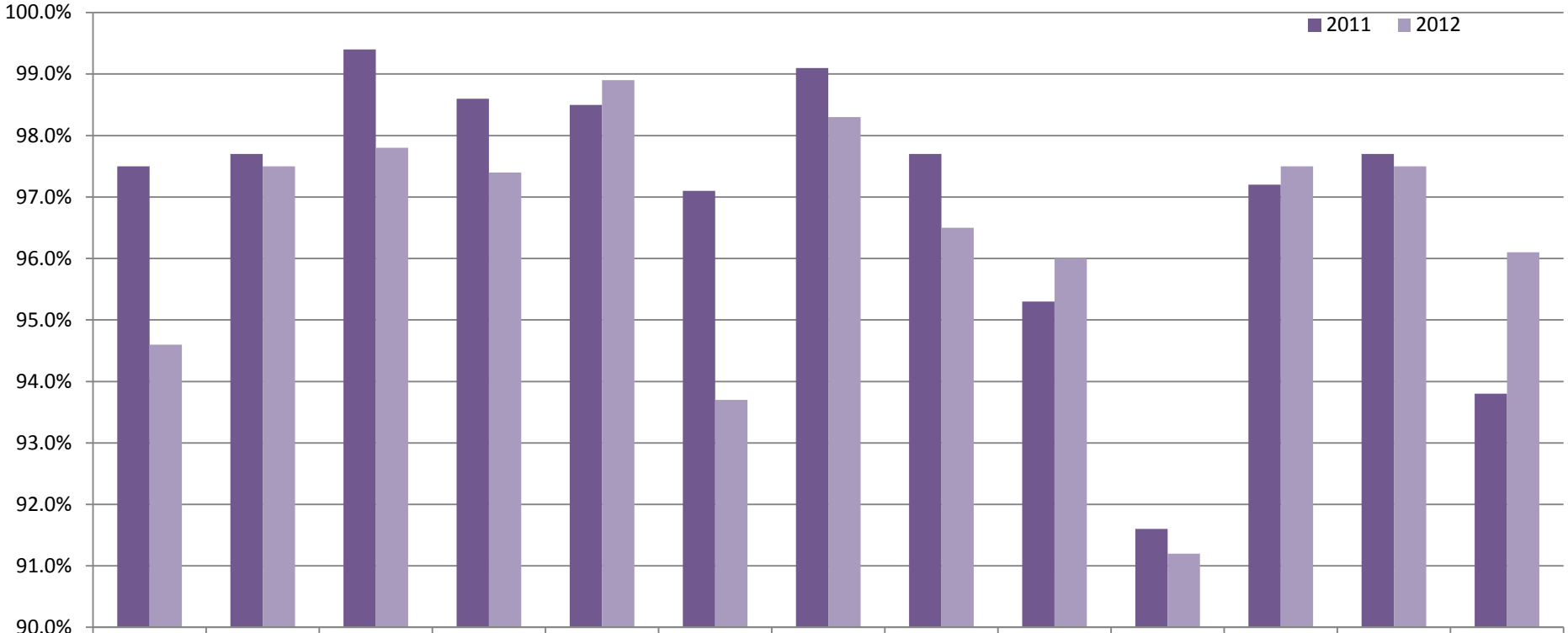
TIMELINES:

Next Routine UR planned for January – March 2013

ATTACHMENTS:

2012 Routine UR Report for QMOC

OVERALL PROVIDER
UTILIZATION REVIEW COMPLIANCE RATES
IN THE NORTH SOUND REGION
JAN - MAR 2011
&
FEB - MAR 2012



	Bridgeways Adult	CCS Child	Compass No. Adult	Compass No. Child	Compass So. Adult	Compass So.Child	Interfaith Adult	LWC Adult	Sea Mar Adult	Sea Mar Child	Sunrise Adult	WCPC Adult	WCPC Child
2011	97.5%	97.7%	99.4%	98.6%	98.5%	97.1%	99.1%	97.7%	95.3%	91.6%	97.2%	97.7%	93.8%
2012	94.6%	97.5%	97.8%	97.4%	98.9%	93.7%	98.3%	96.5%	96.0%	91.2%	97.5%	97.5%	96.1%

UR QUESTIONS SCORING LESS THAN 90% BY PROVIDER FEB - MAR 2012

	UR QUESTION	REGION	Bridgeways Adult	CCS Child	Compass No. Adult	Compass No. Child	Compass So. Adult	Compass So.Child	Interfaith Adult	LWC Adult	Sea Mar Adult	Sea Mar Child	Sunrise Adult	WCPC Adult	WCPC Child
1	The intake was provided by a mental health professional											80.0%			
2	The determination of initial eligibility is consistent with the NSMHA Clinical Eligibility and Care Standards (CECS)														
3	The intake evaluation includes presenting problem(s) as described by the individual and others as applicable including a review of any documentation of a mental health condition provided by the individual														
4	The intake evaluation contains information that current health status, including any medications the individual is taking, was discussed														
5	If during the intake the individual reports having no PCP, a referral to a PCP is offered	87.3%	60.0%			66.7%					50.0%			88.9%	
6	The intake evaluation is age relevant														
7	The intake is culturally relevant														
8	The intake evaluation includes a risk assessment														
9	The intake documents referral for provision of emergency/crisis services, consistent with WAC 388-865-0452, if indicated in the risk assessment.														
10	The intake recommends a course of treatment											69.2%			
11	For admitted individuals 13 and older, a GAIN screening tool has been completed														
12	The intake evaluation documents current substance use and abuse and treatment status														
13	A CA/LOCUS was completed at intake														
14	The chart contains a Recovery/Resiliency Plan (RRP)		87.5%												
15	The RRP was developed within 30 days of the first ongoing outpatient appointment	88.3%	69.6%	89.8%	88.5%	87.5%		77.3%	84.4%			64.7%	89.7%		
16	Goals for treatment are based upon identified mental health needs	89.2%	72.7%				88.2%	78.3%		88.6%	86.4%	77.8%			73.9%
17	The RRP addresses/supports the individual in daily activities appropriate to their age and culture (i.e., employment, education, recreation, socialization, etc)							82.6%							
18	The RRP documents referral to other needed services and supports (i.e., treatment for co-occurring disorders, health care, Children's Administration, DD services, etc)		86.7%					88.9%			88.9%	88.2%			

	UR QUESTION	REGION	Bridgeways Adult	CCS Child	Compass No. Adult	Compass No. Child	Compass So. Adult	Compass So.Child	Interfaith Adult	LWC Adult	Sea Mar Adult	Sea Mar Child	Sunrise Adult	WCPC Adult	WCPC Child
19	The RRP includes goals or objectives that are measurable and that allow the provider and individual to evaluate progress toward the individual's recovery goals											83.3%			
20	The RRP is in language and terminology that is understandable to the individual and family														
21	The RRP was developed collaboratively with the individual, the individual's parent/other legal representative as applicable, and significant others as requested by the individual										80.0%	76.5%			
22	With the individual's consent, or their parent or other legal representative if applicable, or when required the RRP includes coordination with any system or organizations the individual identifies as being relevant to their treatment		83.3%			86.4%		73.7%						85.7%	
23	The treatment proposed/provided is consistent with NSMHA clinical guidelines (Note: In the absence of a NSMHA clinical guideline, generally accepted clinical practice for the individual's diagnosis)		61.9%					77.3%				84.2%			
24	The RRP identifies medically necessary service modalities, mutually agreed upon by the individual and provider, for this treatment episode														
25	The RRP is strength-based	72.2%	60.0%	66.7%	56.0%	56.0%	76.5%	39.1%	87.1%	86.5%		66.7%	82.1%	85.7%	69.6%
26	The RRP addresses age, cultural or disability issues identified by the individual or their parent or other legal representative, if applicable, as relevant to treatment							86.4%							
27	A CA/LOCUS has been done at the review date or when clinically indicated (NSMHA)		77.8%		50.0%										
28	The determination of eligibility for continued stay is consistent with NSMHA Clinical Eligibility and Care Standards (CECS)									87.1%		80.0%			83.3%
29	The clinical record contains information indicating that mental health services history was discussed, including any previously accessed inpatient or outpatient services and/or medications to treat a mental health condition														
30	The clinical record identifies strengths and resources of the individual/family that can be used in the course of treatment/recovery														
31	The clinical record identifies the individual's disability or special needs														
32	There is sufficient evidence to support the most recent diagnosis, including provisional diagnoses, identified in the clinical record		86.2%					84.6%		87.2%		57.7%	82.9%		
33	The clinical record contains documentation of the name of any current primary medical care provider		86.2%											87.5%	
34	The clinical record contains documentation of any current physical health concerns														

	UR QUESTION	REGION	Bridgeways Adult	CCS Child	Compass No. Adult	Compass No. Child	Compass So. Adult	Compass So.Child	Interfaith Adult	LWC Adult	Sea Mar Adult	Sea Mar Child	Sunrise Adult	WCPC Adult	WCPC Child
35	The clinical record contains documentation of history of any substance use/abuse and treatment														
36	The clinical record contains information about past or current trauma or abuse														
37	The clinical record contains a description of the individual's self-identified culture											81.8%			
38	The treatment (types of services and interventions) identified on the RRP has been implemented														
39	The clinical record contains documentation of objective progress toward established goals on the RRP														
40	The clinical record reflects intensity and frequency of interventions that correspond with the individual's needs and severity of symptoms and vary over time as appropriate			85.4%											
41	The clinical record contains documentation of how any major changes in the individual's circumstances were addressed														
42	If the individual has repeated cancellations and/or "No Shows", there is evidence that the intensity of the efforts to re-engage the individual were congruent with the individual's identified need/risk			80.0%				85.7%	86.7%		77.8%				85.7%
43	Risk factors are continually monitored and addressed throughout the treatment episode														
44	When required (LOC 4 and above), requested or clinically indicated, a crisis plan exists			71.4%				66.7%	83.3%		75.0%	33.3%			0.0%
45	The crisis plan includes early warning signs of decompensation													83.3%	
46	The crisis plan clearly defines a process by which to contact formal and/or informal supports including how to connect the individual/family directly to the emergency crisis intervention services										66.7%			83.3%	
47	The crisis plan focuses on individual health and safety										66.7%			50.0%	
48	The crisis plan focuses on family/others health and safety										66.7%			60.0%	
49	The crisis plan includes individual's roles, directives and responsibilities										66.7%			83.3%	
50	The crisis plan includes family/other's roles, directives and responsibilities										66.7%			75.0%	
51	The crisis plan includes proactive and progressive measures to divert or prevent crisis													83.3%	

	UR QUESTION	REGION	Bridgeways Adult	CCS Child	Compass No. Adult	Compass No. Child	Compass So. Adult	Compass So.Child	Interfaith Adult	LWC Adult	Sea Mar Adult	Sea Mar Child	Sunrise Adult	WCPC Adult	WCPC Child
52	The crisis plan includes the individual's voice													83.3%	
53	Referral for medication evaluation is provided when clinically indicated														71.4%
54	The agency is prescribing psychiatric medications														
55	If prescribed by agency staff, the intensity of medication monitoring is sufficient to meet the individual's need										81.8%	0.0%			
56	The clinical/medical record contains documentation that individuals and, as appropriate, family members are informed about the medication prescribed and possible side effects in language that is understandable to the individual	89.8%				50.0%				72.2%					75.0%
57	The clinical/medical record contains both the name and purpose of the medication prescribed					50.0%				88.9%					75.0%
58	The clinical/medical record contains both the name and signature of the prescribing person														
59	The clinical/medical record contains the prescribing authority's reason for changing or stopping the medication										83.3%				
60	The clinical/medical record includes documentation of the medications' effects, interactions, and side effects staff observe or individual reports spontaneously or as a result of questions from staff														0.0%
61	There is a delineation of psychiatric and non psychiatric medications		66.7%												
62	There is evidence of communication between the prescribers of the delineated psychiatric and non psychiatric medications														
63	If there is an indication that abuse, neglect or exploitation is suspected or evident, there is documentation in the chart that this was reported to the appropriate authorities														

Standard also identified below 90% in 2010 and/or 2011